S. Hrg. 98-1193

HEALTH CARE COSTS AND THEIR EFFECTS ON THE ECONOMY

HEARINGS

BEFORE THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

NINETY-EIGHTH CONGRESS

SECOND SESSION

APRIL 12 AND AUGUST 29, 1984

Printed for use of the Joint Economic Committee

U.S. GOVERNMENT PRINTING OFFICE
37-264 O WASHINGTON : 1984

J841-19

JOINT ECONOMIC COMMITTEE

(Created pursuant to sec. 5(a) of Public Law 304, 79th Congress)

SENATE

ROGER W. JEPSEN, Iowa, *Chairman*
WILLIAM V. ROTH, Jr., Delaware
JAMES ABDNOR, South Dakota
STEVEN D. SYMMS, Idaho
MACK MATTINGLY, Georgia
ALFONSE M. D'AMATO, New York
LLOYD BENTSEN, Texas
WILLIAM PROXMIRE, Wisconsin
EDWARD M. KENNEDY, Massachusetts
PAUL S. SARBANES, Maryland

HOUSE OF REPRESENTATIVES

LEE H. HAMILTON, Indiana, *Vice Chairman*
GILLIS W. LONG, Louisiana
PARREN J. MITCHELL, Maryland
AUGUSTUS F. HAWKINS, California
DAVID R. OBEY, Wisconsin
JAMES H. SCHEUER, New York
CHALMERS P. WYLIE, Ohio
MARJORIE S. HOLT, Maryland
DANIEL E. LUNGREN, California
OLYMPIA J. SNOWE, Maine

CHARLES H. BRADFORD, *Acting Executive Director* [1]
JAMES K. GALBRAITH, *Deputy Director*

---

[1] Mr. Bradford was acting executive director from Mar. 23 to Apr. 29, 1984. Dan C. Roberts was appointed as executive director on Apr. 30, 1984.

CONTENTS

WITNESSES AND STATEMENTS

THURSDAY, APRIL 12, 1984

Page

Jepsen, Hon. Roger W., chairman of the Joint Economic Committee: Opening statement ... 1
Califano, Hon. Joseph A., Jr., a director, Chrysler Corp.; chairman, Chrysler Board of Directors Committee on Health Care; and former Secretary of Health, Education, and Welfare ... 4
Shelton, Jack K., manager, employee insurance department, Ford Motor Co ... 32
White, Mrs. Bert, chairman, Farm Bureau Women's Committee, American Farm Bureau Federation ... 58
Goldbeck, Willis B., president, Washington Business Group on Health ... 66
Hacking, James, assistant legislative counsel, American Association of Retired Persons, accompanied by Jack Christy, legislative representative ... 93
Owen, Jack, executive vice president, American Hospital Association ... 127
Nelson, Alan R., M.D., member, board of trustees, American Medical Association, accompanied by Ross Rubin, director, Department of Federal Legislation, AMA ... 141
Suther, Mary, chief executive officer, Visiting Nurse Association of Dallas, TX, on behalf of the National Association for Home Care ... 165
Dorsch, James A., Washington counsel, Health Insurance Association of America ... 178

WEDNESDAY, AUGUST 29, 1984

Jepsen, Hon. Roger W., chairman of the Joint Economic Committee: Opening statement ... 197
Beckett, Julie, Cedar Rapids, IA ... 199
Shipley, James E., president, Iowa Health Care Association, Anamosa, IA ... 201
McLaughlin, James N., Monticello, IA ... 202
Pos, Wayne, legislative chairman, Iowa Retired Teachers Association, Des Moines, IA ... 203
Roquette, Denise, Cedar Rapids, IA ... 205
Miller, Jodi, Cedar Rapids, IA ... 206
Flanagan, Jean, Cedar Rapids, IA ... 207
Swaney, Robert L., M.D., president, Linn County Medical Society, Cedar Rapids, IA, representing the Iowa Medical Society ... 209
Wallace, Samuel T., president, St. Luke's Hospital, Cedar Rapids, IA ... 214
Miller, Sara B., administrator, Anamosa Community Hospital, Anamosa, IA ... 216
Levitz, Gary S., assistant to the director, University of Iowa Hospitals and Clinics, Cedar Rapids, IA, presented on behalf of John W. Colloton, director of University of Iowa Hospitals and Clinics and assistant to the university president for Statewide Services ... 218
Tinker, Jim, administrator, Mercy Hospital, Cedar Rapids, IA ... 222
Muenchow, Judie, executive director, Visiting Nurse Association, Cedar Rapids, IA ... 225
Phillips, Madge, director, Linn County Health Center, Cedar Rapids, IA ... 230
Oakley, Brice, senior associate counsel, Blue Cross and Blue Shield of Iowa, Des Moines, IA ... 234
Hegwood, Jackie, operations supervisor, Social Security district office, Cedar Rapids, IA ... 238

Page
Tilghman, Joe, deputy regional administrator, Health Care Financing Administration, Kansas City regional office, Kansas City, MO ---------- 239
Weber, John, medical sales representative, Midwest sales region, Hewlett-Packard Co., Cedar Rapids, IA ---------- 247
Snyder, James R., attorney, Simmons, Perrine, Albright & Ellwood, Cedar Rapids, IA ---------- 248
Knuth, Russell, Pioneer Hi-Bred International, Inc., Johnson, IA ---------- 253
Petras, Edward J., acting director, HMO Medical Association, Dubuque, IA ---------- 258
Grahek, Bernard M., clinical coordinator, Voluntary Hospitals Cooperative Association of Iowa, Cedar Rapids, IA ---------- 260
Johnson, G. Richard, Rockwell International, Cedar Rapids, IA ---------- 262

SUBMISSIONS FOR THE RECORD

THURSDAY, APRIL 12, 1984

Califano, Hon. Joseph A., Jr.: Prepared statement ---------- 11
Dorsch, James A.: Prepared statement ---------- 180
Goldbeck, Willis B.: Prepared statement ---------- 70
Hacking, James, et al.: Prepared statement ---------- 96
Nelson, Alan R., M.D., et al.: Prepared statement ---------- 145
Owen, Jack: Prepared statement ---------- 132
Shelton, Jack K.: Prepared statement ---------- 35
Suther, Mary: Prepared statement ---------- 170
White, Mrs. Bert: Prepared statement ---------- 61

WEDNESDAY, AUGUST 29, 1984

Knuth, Russell: Brochure entitled "The Health Guard Program for Pioneer Employees" ---------- 256
Oakley, Brice: Prepared statement ---------- 236
Phillips, Madge: Prepared statement ---------- 233
Snyder, James R.: Prepared statement ---------- 250
Swaney, Robert L., M.D.: Prepared statement ---------- 211
Tilghman, Joe: Prepared statement ---------- 242

APPENDIX

Article entitled: "Gripes About Health Care Aired at Congressional Hearing," by Vanessa Shelton, from the Cedar Rapids Gazette, Aug. 30, 1984 ---------- 267
Letters to Senator Jepsen and Senator Grassley from Iowa constituents regarding high health care costs ---------- 271

HEALTH CARE COSTS AND THEIR EFFECTS ON THE ECONOMY

THURSDAY, APRIL 12, 1984

Congress of the United States,
Joint Economic Committee,
Washington, DC.

The committee met, pursuant to notice, at 9:40 a.m., in room SD-628, Dirksen Senate Office Building, Hon. Roger W. Jepsen (chairman of the committee) presiding.

Present: Senator Jepsen.

Also present: William Finerfrock, legislative assistant to Senator Jepsen; and Mary E. Eccles, professional staff member.

OPENING STATEMENT OF SENATOR JEPSEN, CHAIRMAN

Senator Jepsen. We now call this hearing to order.

The topic of today's hearing is health care costs and their effects on the economy.

First of all, I would like to take this opportunity to thank all of the witnesses and the guests here this morning for taking the time to be here. I know that the testimony presented today will make all our time well spent.

Several months ago, I was talking with a group of Iowans about health care costs and someone asked the question, "Who's to blame for skyrocketing health care costs?" One person in the group offered that it was the doctors' fault, another suggested that perhaps the hospitals were to blame, still another suggested that actually it was neither, but rather it was the insurance companies that were driving up the cost of health care. I'm sure this is familiar and you've heard that type of roundrobin discussion before.

Well, as we discussed the matter further, we came to the conclusion that it was really unfair to blame just the doctors or the hospitals or the insurance companies; that indeed, consumers, business, and government had to share in the blame as well. I suppose the question, "Who's to blame for skyrocketing health care costs?" can best be answered by the cartoon character Pogo who once stated, "We has met the enemy and it is us."

Whenever I get into a discussion about health care costs, I am reminded of a statement made by a former classmate of mine who, upon leaving an examination room was asked, "How were the questions on the exam? Did you have any trouble?" without hesitating, my friend replied, "The questions were easy. It was the answers that I had trouble with."

As I get more and more involved in the health care debate, I find that the vast majority of people are all asking the right questions; it's the answers that we are having trouble with right now.

Now I won't suggest that in one hearing or one series of hearings we will be able to come up with the answers to the health care cost problem, but it is my hope that perhaps we will be able to gain a better understanding of the problems being faced by consumers, businesses, providers, and insurers so that when we talk about possible solutions it will be based upon a common understanding of the problem.

As these charts indicate, health care costs have gone from approximately 5 percent of our gross national product in 1950 to almost 11 percent of our gross national product in 1982. Current estimates are for this rise to continue throughout the remainder of this decade and on in to the next century. Now to put this into perspective, health care costs, as a percentage of our gross national product, are rising faster than either the defense budget or Social Security.

But rising health care costs are more than just statistics or percentages of the gross national product. Those costs are coming out of the pockets of hard-working men and women. Those costs are being borne by elderly citizens who see health care eating more and more into their retirement income. Those costs are being paid by consumers in increased costs of goods and services.

Lest anyone get the wrong idea, that money isn't being thrown down a bottomless hole. We are getting something for those dollars and that something is the finest quality health care in the world. Overutilization is not the only reason that health care costs have gone up. If we want to go back to paying the same for health care that we paid in 1950, then we must also expect that we will get the same quality of health care we got in 1950.

For many years, the American people have become accustomed to hearing debate at the national level on the various policies of the Federal Government—defense policy, economic policy, tax policy, welfare policy, and most recently, industrial policy.

Of equal importance but only recently focused upon, is the question of health policy.

Everyone agrees that health care costs have been a major concern of consumers, providers, insurers, and government officials for quite some time. But other than examining health care costs as they affect the medicare and medicaid programs, little attention has been paid to health care costs as they affect the rest of the country.

As the chart indicates, health care costs have been skyrocketing for quite some time.

When I first discussed the idea of conducting a series of Joint Economic Committee hearings on the problem of health care costs as they affect the economy, I was met with the question: "Why should the Joint Economic Committee do this?"

As everyone knows, the Joint Economic Committee does not have a legislative mandate, but rather is charged with taking a broad look at Government policy and attempting to determine the economic impact of those policies. For this reason, I believe this committee is uniquely qualified to look at the problems of health care costs because we are not restrained by the boundaries of the medicare or medicaid programs. Nor are we limited in the kinds of ways we can look at the effects of health care costs.

As the agenda indicates, today's hearing will seek to present testimony from a wide variety of witnesses representing some very divergent viewpoints. It was my hope in selecting these witnesses to get as broad a spectrum of viewpoints as possible. For this reason, we have witnesses representing business, health providers, and consumers.

I think that if I had to choose one word to describe the goal we are all striving for, it would be affordability. That connotes accessibility. The American people have come to expect affordable health care as a right. Frankly, I don't think this is an unreasonable expectation.

As a caring and compassionate society, we must be willing to recognize that adequate and affordable health care is not a luxury but rather a necessity. As such, we must be prepared to take those steps necessary to bring this goal about.

As we strive for affordability, however, we cannot overlook the need to maintain quality.

After all, if it is a relative of yours on the operating table, you want to know that the physicians and staff performing the surgery are well-trained and qualified to be doing the delicate job.

That quality costs money.

Someone has to pay for the training that went into educating the doctors and nurses.

Someone has to pay for the research that went into developing the drugs being administered.

And someone has to pay for the high-tech equipment being used to diagnose and monitor the patient.

In concluding my remarks, I would refer to the other two charts we have there and show that used on the basis of 100 in 1970 we find that whereas medical care has risen as illustrated by the green line, the Consumer Price Index has risen along with it, but medical care is rising slightly higher than the Consumer Price Index or inflation. We find the cost of a hospital room has risen nearly twice as much in the same period of time. Employer contributions for employee health insurance from 1950 to 1983—we started out with about $780 million in contributions and in 1983 it was $70.7 billion.

Interestingly enough, the medicare-medicaid costs were projected to cost $7 billion by 1990 and it was around $77 billion in 1982. That's quite a marked degree of similarity. In any event, it's a lot of money. We've got some problems.

I would like to once again thank everyone for attending this hearing and I look forward to hearing the testimony of all of our witnesses. We are going to have this morning the format that will be divided into four panels. Each panelist has been asked to summarize his or her statement with the understanding that the entire statement will appear in the record as if read. After all the panelists have presented their oral testimony, then there will be time available for exchange of ideas as well as questions. Now we have copies of everyone that is testifying today. I'd like to remind the panelists that we're asking that you summarize the key points, and I'd also like to mention and advise that this hearing is being televised by the C-SPAN cable network and as such we may have people watching who are not familiar with some of the terms or the abbreviations that we use around the Capitol here and that we kind of take for granted. For instance, many people don't know what an HMO is or never heard of PPO, and if you intend to use those terms excessively I'd ask you to please explain these during the question and answer period or as you refer to them.

I'd like to welcome the first panel: the Honorable Joseph Califano, former Secretary of Health, Education, and Welfare. Mr. Califano is presently serving on the board of directors of the Chrysler Corp. and will be testifying on their behalf. And Mr. Jack Shelton, manager, employee insurance department for the Ford Motor Co. Mr. Shelton will be testifying on behalf of Ford.

I thank you—in the jargon of the lingo that they use around the Capitol here—I thank you gentlemen for taking time out of your busy schedule to be here on this most beautiful day to share with us your expertise in this field.

You may proceed, Mr. Califano.

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., A DIRECTOR, CHRYSLER CORP.; CHAIRMAN, CHRYSLER BOARD OF DIRECTORS COMMITTEE ON HEALTH CARE; AND FORMER SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Mr. CALIFANO. Thank you, Mr. Chairman. I will read some excerpts from my statement and I appreciate the entire statement being put in the record.

I appreciate the opportunity to testify on health care costs and their effects on the economy.

The Chrysler Corp. is deeply concerned about rocketing health care costs and believes that our Nation must formulate a national health policy if we are to bring these costs under control.

The persistent, unbridled, inflationary rise in health care costs is an unfair burden for millions of our citizen-consumers, and for American business as it seeks to compete with foreign industry. We must reduce the cost of delivering high quality health care to our people.

True reductions in costs will come only from fundamental changes in the way we deliver and pay for health care. Those changes require concerted action by all the players—employers and unions, the administration and the Congress, Federal, State, and local government, lawyers, insurance companies, and the doctors, hospitals, laboratories, drug companies, and other suppliers.

Unfortunately, the structure of the health care industry is such that caps on payments by one purchaser produce largely illusionary savings. The suppliers simply shift costs to other purchasers or to other parts of the system.

Controlling health care costs has become the great health care cost shell game. The Congress puts a cap on medicare payments to hospitals and the hospitals just pass the costs off to the States. The States put their own caps on medicaid hospital payments and the hospitals just move the pea to the private insurers and the Blues. The Congress establishes caps on medical procedures in hospitals and the doctors move the pea outside the hospital to their offices or clinics.

It's time, Mr. Chairman, to end the shell game and establish a comprehensive national policy to deal with health care costs.

The statistics regarding health care costs are shocking. I won't repeat what you said, Mr. Chairman, but I would note that this month, for the first time in the history of our country, Americans are spending more than $1 billion a day on health care.

These structural characteristics create a Frankenstein health care payment system, with gargantuan growth on the supply side as we train more physicians, build more hospital beds and invent more expensive medical technologies, and with little, if any, resistance on the demand side.

The creation of this health care cost monster did not spring from the brain of some demented doctor. We all contributed mightily to the effort.

American businesses, experiencing high growth in the post-World War II period, has little concern as they expanded health care benefits. After all, health care seemed a lot less expensive to give employees than a higher per hour wage.

Unions demanded more health care coverage for their members, especially since health premiums were tax-free fringe benefits to workers. With each round of bargaining, managers who fought with other suppliers over the price of each nail or screw and union leaders who negotiated for each half-cent an hour kept adding health benefits to contracts without realizing that they were becoming hostage to costs beyond their control—costs that over the long run endangered jobs and hobbled profits.

The Government also made its contribution. When the Medicare and Medicaid Programs were instituted in the 1960's, the Government was preoccupied with improving access to health care for the elderly and the poor. So we paid the political price by simply superimposing those programs on the existing cost-based, fee-for-service system.

The doctors and hospitals initially resisted these government programs. But once the Congress legislated the fee-for-service, cost and cost-plus reimbursement system into them, the doctors and hospital administrators cheerfully joined in the creation of this swollen health care cost monster.

Lawyers, judges, and juries fed this Frankenstein by malpractice litigation that established unpredictable and unrealistic standards of negligence and whopping judgments against doctors and hospitals who failed to run one test or another.

It's not a new problem, Mr. Chairman. In 1968, President Lyndon Johnson sent Congress a message on "Health in America" citing three major deficiencies with the structure of the health care market:

Health insurance plans—that—encourage doctors and patients to choose hospitalization even when other, less costly forms of care would be equally effective;

The fee-for-service system of paying physicians with no strong economic incentives to encourage them to avoid providing care that is unnecessary; and

Hospitals—that—charge on a cost basis which places no penalty on inefficient operations.

President Johnson asked for legislation to test new payment systems. Congress refused to give him that legislation that year and it has failed to act decisively since then, despite the repeated entreaties of every President since Lyndon Johnson.

At Chrysler, as we fought for survival, we had to address the cost of health care.

It has not been an easy task. In 1984, Chrysler's health care costs will exceed $400 million, making the Blues Chrysler's single largest supplier. That's more than $1.1 million each day. This year Chrysler's total health care bill—which includes Chrysler's medicare payroll tax and a portion of the health insurance premiums of its suppliers—will exceed $550 for each car we sell. That's down somewhat from $600 a car last year—not because inflation in health care costs has abated, but because we are selling more cars.

The cost of Chrysler's Health Care Program—which covers employees, retirees and their dependents—grew from $295 per active employee in 1964 to some $5,700 per active employee today. Chrysler's overall health insurance premium jumped from $81 million in 1970 to $364 million in 1983. This year Chrysler must sell about 70,000 vehicles just to pay for its health care bills.

If something isn't done to reduce projected increases, Chrysler's health care costs could exceed $1 billion in 10 years, or $16,000 per active worker.

If we could hold Chrysler's 1984 projected health care costs to a growth rate even 50 percent greater than the Consumer Price Index, we could save $25 million this year. If Chrysler could reduce the rate of increase in its health care costs just 1 percent, Chrysler could save more than $400 million over the next 10 years.

Excessive health care costs are eroding America's ability to compete with foreign companies, a subject you asked us to address, Mr. Chairman. Mitsubishi Motor Corp., a Japanese car manufacturer in which Chrysler has an investment, spends only $815 a year for an employee's health care costs while each employee pays approximately $374. Unlike Chrysler, Mitsubishi has no direct cost for retirees or their surviving spouses because of Japan's national health coverage. Chrysler's comparable cost per active employee is $5,700—400 percent higher than Mitsubishi's cost.

That gap may well increase. The Japanese Government is moving aggressively to control health care utilization by seeking a law to require a substantial copayment for employees, beginning at 10 percent and rising to 20 percent.

What does Chrysler get for its health care dollar? A health care industry that is expensive, wasteful, and inefficient. Let me share with you a few examples of what we are discovering as we analyze our own health care plan in depth.

Among the Nation's medicare recipients, one of the top medical procedures performed is cataract surgery. The procedure takes about 20 minutes and rarely requires a general anesthetic.

The average opthamologist charge for this procedure in the Detroit area is about $2,000. If a doctor performed three of these procedures a day, 4 days a week, 42 weeks a year, he would earn more than $1 million, for less than 200 hours of actual surgery, and have a 10-week vacation to boot.

Compare this with the typical charge of $1,500 for serious abdominal surgery lasting 4 to 5 hours.

We asked some doctors to investigate eight Detroit area hospitals with extraordinarily high percentages of nonsurgical admissions for low back problems. This study showed that two-thirds of the hospitalizations—and 2,264 out of 2,677 of the total hospital days, approximately 85 percent—were inappropriate.

With respect to three of the hospitals audited, none of the admissions were found to be appropriate.

Our physician experts investigated the six Detroit area hospitals with the highest number of maternity admissions for our insured. In more than 80 percent of the 618 cases studied, one or more of the hospital days were found to be unnecessary—a total of over 1,000 inappropriate days, almost a quarter of the time spent in the hospital.

We have no reason to believe that Chrysler's experience is unique. Similar waste and inefficiency exists in almost every health benefit program in this country. Chrysler's preliminary investigation suggests that as much as 25 percent of its hospital costs may be due to waste and inefficiency. For Chrysler, elimination of those costs would save almost $50 million in 1984.

Other studies have also found substantial evidence of inappropriate or unnecessary hospitalization. We cite them in the testimony. If we reduced the number of hospital days expected in 1984 by 25 percent, we would save more than $60 billion—without adversely affecting the quality of care.

Chrysler is not sitting still. In less than 2 years, we have acted to save nearly $10 million annually.

We set up a screening program for foot surgery, which cut utilization 60 percent and saves over $1 million a year.

We began a program to promote generic drugs which saves $250,000 a year.

We mandated second medical opinions before certain elective surgeries, which saves $1 million a year.

We instituted programs to encourage outpatient surgery, which save $2 million a year.

We have started a new program in Michigan to screen hospital admissions and control lengths of stay for Chrysler's nonbargaining unit employees. We project a savings of $2 million in its first year. If we could extend this program to Chrysler's United Auto Worker employees, which would require union agreement, we estimate we could save $9 million in the first year.

We mounted an intensive communication program to educate both employees and health care providers about these new corporation initiatives and the cost of health care.

These steps are only the beginning. We are currently exploring several preferred provider arrangements, including programs for outpatient psychiatric services, laboratory tests, and prescription drugs.

In short, Chrysler is trying to do everything it can to control health care costs by eliminating waste and inefficiency. But Chrysler and American business cannot along control health care costs. We need help to restructure the financial incentives in America's health care industry to eliminate its inefficiencies, and, where possible, to instill some marketplace discipline and competition.

More than 60 percent of the costs of hospital care are paid by Federal, State, and local government. Unless public expenditures and Federal and State cost containment measures are part of a national health policy, it is inevitable that cost shifting will continue to occur.

Sleight of hand tricks do not reduce health care costs. Costs disappearing from the Federal health care budget have a remarkable ability to reappear elsewhere in the system. In the case of many elderly patients, for example, the incentive in the medicare DRG cap for early discharge of hospital patients translates into early admission to nursing homes. The Federal Government plays this shell game because medicaid pays for most nursing home care, and the States pay half the medicaid bill—while the Federal Government gets no State help in paying the medicare bill.

Another variant of the health care costs shell game is the trend to ambulatory surgery that has caused an explosion of new investment in equipment and physical plant for outpatient surgery centers, without any concomitant reduction in hospital beds. As a result, hospitals continue to have the same high fixed costs, which must now be spread over fewer patients.

Rather than reducing the cost of health care by eliminating the inefficiencies and waste in the system, the Federal Government and the States have thus far found it easier to refuse to pay their share, grabbing credit for reducing budget deficits, when they are only hiding the actual health care costs under another shell. Rather than attack the structural defects in the health care financing system, the Congress and the administration have opted to impose a hidden tax on American business and American citizens. The Federal Government's savings are the increased costs for business and individuals.

Just an example or two of what recent Federal policy means to Chrysler.

In order to stave off bankruptcy in 1979, Chrysler had to shrink its active work force. Chrysler now pays for health care for nearly as many retirees and dependents as active employees and their dependents. Moreover, the retirees are aging, averaging almost 69 years and getting older. We have more than 14,000 retirees age 75 or older; 6,000 are 80 or older.

For its retirees, Chrysler pays for many health care services not paid by medicare. Therefore, as medicare seeks to ease its own financial crisis by shifting costs to the individual, if that beneficiary is a Chrysler retiree, we pick up the cost.

In 1965, a medicare beneficiary had to pay the first $40 of a hospital stay; today that copayment is $356. Similarly, the daily copayment for long-term hospital stays has risen from $10 to $89 per day—for the 60th to the 90th day of an admission. Chrysler absorbs 100 percent of these increases. The latest increase in the hospital deductible alone of medicare will cost Chrysler approximately $1 million a year. Our citizens haven't saved anything. Our Government has simply hidden the pea under another shell.

Here is one classic example of how the great health care cost shell game affects Chrysler: The Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA] requires the employer's group health insurance to provide the primary coverage for employees and their spouses over age 65. That provision does not save our people a single dollar. It simply shifts the pea from medicare to the private sector. The cost to Chrysler is $1.4 million in 1983 and will increase annually. The cost to all U.S. businesses is over $1.5 billion.

Some of the proposals for rescuing medicare are outrageous examples of the health care cost shell game. For example, the proposal by the Advisory Council on Social Security to delay medicare eligibility from age 65 to age 67 would cost Chrysler approximately $100 million over the next 5 years. Over the next 10 years, the delay would cost American business and citizens some $75 billion. It would shift the cost personally to citizens not fortunate enough to have such coverage like Chrysler's. And it would not eliminate a single dollar of waste or inefficiency in the health care system.

This Nation cannot afford further delay in establishing a national policy to address the health care cost crisis. The graying of America is forcing the issue, with an ever-growing population demanding more expensive high technology hospital care.

The effect of the aging of our population on health care costs is sobering. The Congressional Budget Office now projects that Medicare's Hospital Insurance Trust Fund will go bust by the early 1990's.

Yet, the Hospital Fund crisis is only the tip of the iceberg. Many thoughtful Americans are deeply concerned about the frightening levels of unfunded pension liability in our country. The crisis in the Social Security system is the forerunner of far more serious financial crises as we face up to unfunded Government and private sector pension liabilities that many fear approach $1 trillion.

But few Americans have even begun to think about the unfunded health care liabilities of our Nation. As our health care costs increase and our population ages, the present, unfunded postemployment health care cost liability of the Fortune 500 American companies alone—with about 15 million active employees—approaches $2 trillion. The total assets of those companies was only $1.3 trillion in 1982.

That unfunded liability number alone should make us all realize that in health care costs we face the greatest financial and social crisis in this Nation's history.

Congress must begin to address the costs across the health care system, and we welcome these hearings in that direction, Mr. Chairman.

As a first step, we recommend that the Congress this year enact legislation to establish a National Commission on Health Care Reform, similar to the National Commission on Social Security Reform. The Commission's charge should be to develop a national health policy, and its membership should include representatives of all interested parties—Federal, State, and local governments, business and labor, senior citizens and junior citizens, lawyers, physicians, hospitals, and health insurers. The Commission can provide a forum to develop a comprehensive strategy to reduce costs without reducing care. The Commission should be required to make its report to the administration, the Congress, and the American people within 1 year, so that the next Congress can act.

We must create an efficient health care delivery system. We can't keep going the way we are. We simply don't have the money.

That stark fact presages a terrifying triage for the American people, and a debate over euthanasia more searing than our debate over abortion. In "The Painful Prescription," a book just published by Henry Aaron and William Schwartz at Brookings, the authors argue persuasively that, like Great Britain, we will soon ration health care in our country.

We always have had rationing, of course, related to individual economic wealth. But, with medicare, the Government becomes the rationer of health care for those who use and need the acute care system most—the elderly and the disabled. This role is reinforced by the fact that the Federal Government funds 90 percent of all the basic biomedical research in America, and, together with State and local governments, pays most hospital bills.

Bluntly put, Uncle Sam will soon be playing King Solomon with your father and mother and mine, and with you and me.

We face a frightening specter in our Nation as medical technology and spiraling costs combine to blur the lines in hospital rooms among natural death, euthanasia, suicide, and murder.

Without the most energetic pursuit of efficiencies, we will soon face a world in which there is no kidney dialysis for people over 55, no hip operations—or artificial hips—for those over 65, a world in which eligibility for expensive anticancer therapy will be based on statistical assessments of success, and key organ transplants will be severely limited to special cases of virtually certain recovery—all as defined in pages and pages of Government regulations.

What kind of a vision for the future is that? It's not a very pleasant one. But in Great Britain that future is now. That's just what they do today.

We in America are fortunate because we still have time to avoid that fate. We can learn from Britain's experience. We have a far more productive society. We can well afford to provide quality medical care to all. But we must have a coherent national health policy which will eliminate inefficiencies and reduce the cost of health care for our society as a whole.

These issues, which go to the very sanctity of human life, are what make these hearings so important and your responsibilities as legislators so special.

[The prepared statement of Mr. Califano follows:]

PREPARED STATEMENT OF HON. JOSEPH A. CALIFANO, JR.

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to testify on Health Care Costs and their effects on the economy.

The Chrysler Corporation is deeply concerned about rocketing health care costs and believes that our Nation must formulate a national health policy if we are to bring these costs under control.

The persistent, unbridled, inflationary rise in health care costs is an unfair burden for millions of our citizen-consumers, and for American business as it seeks to compete with foreign industry. We must reduce the cost of delivering high quality health care to our people.

True reductions in costs will come only from fundamental changes in the way we deliver and pay for health care. Those changes require concerted action by all the players -- employers and unions, the Administration and the Congress, federal, state and local government, lawyers, and the doctors, hospitals, laboratories, drug companies and other suppliers.

Unfortunately, the structure of the health care industry is such that caps on payments by one purchaser produce largely illusionary savings. The suppliers simply shift costs to other purchasers or to other parts of the system.

Controlling health care costs has become the Great Health Care Cost Shell Game. The Congress puts a cap on Medicare payments to hospitals and the hospitals just pass the costs off to the states. The states put their own caps on Medicaid hospital payments and the hospitals just move the pea to the private insurers and the Blues. The Congress establishes caps on medical procedures in hospitals and the doctors move the pea outside the hospital to their offices or clinics.

It's time to end the shell game and establish a comprehensive national policy to deal with health care costs.

The statistics regarding health care costs are shocking.

- This month, for the first time in our history, Americans are spending more than $1 billion a day on health care.
- Health care costs rose from $41.7 billion in 1965 to $355 billion in 1983 -- an increase of 770 percent.
- Hospital costs jumped from $13.9 billion in 1965 to $150 billion in 1983 -- an increase of 979 percent.
- Physicians fees increased from $8.5 billion in 1965 to $68.1 billion -- an increase of 700 percent.
- Over that period, the Consumer Price Index rose -- but only by 242 percent.

And health care is still the most inflationary sector of the economy. In 1983, the cost of medical care rose at a ten percent rate, more than triple the 3.2 percent increase in the overall consumer price index. The daily cost of a hospital room rose 12.2 percent, to an average of almost $400 per day. The 1983 bill of $355 billion was a levy of almost $1,500 on every man, woman and child in America. Last year, some 15 cents of every federal tax dollar went to the health care industry.

This year health care continues its inflationary assault on the American economy.

There is no longer much disagreement about the structural causes of inflation in the health care industry. Everyone working in the system is acting in response to the economic incentives they face.

First, hospitals have generally been reimbursed on a cost, or in the case of for-profit hospitals, a cost-plus basis. Doctors are paid on a fee for service basis. Thus, the more hospitals have spent, the more money they have received; the more services doctors perform, the more money they make.

The new Medicare prospective payment system -- setting payments for 467 health diagnoses from appendectomies to gall bladder operations -- is a step in the right direction. But even with this Diagnostic Related Group (DRG) system, Medicare continues to fund capital expenditures and physician training on a cost basis. And the DRG system is part of the Great Health Care Cost Shell Game: It lets the hospitals shift the pea to the states and private insurers, and it lets the doctors shift the pea out of the hospital and into their offices where there are no cost containment caps.

Second -- and of critical importance as we think of the potential for a competitive economy in health care -- the prevailing third party payment system eliminates any relationship between the buyer and the seller. When an American buys an automobile, he or she picks a dealer, negotiates about model, price, terms of payment, optional equipment, color, trim. Then the buyer picks the car he or she wants, and pays for it.

But no one enters a hospital and says, "I would like an appendectomy today," or "I would like a hysterectomy tomorrow." Where hospitalization is involved, the patient doesn't even pick the surgeon or specialist; the family physician does. That specialist prescribes the medical procedures and picks the hospital at which they will be performed. Knowing he is not likely to be sued for conducting an extra test, the doctor has every incentive to run lots of tests. And so does the hospital, since its charges for tests help pay for the expensive equipment used to conduct them.

The doctor ordering up the medical procedures and tests doesn't pay the bill. And the patient has no sense of paying it. More than ninety-four percent of hospital bills are paid by the government programs like Medicare and Medicaid, private insurers and the Blues.

These structural characteristics create a Frankenstein health care payment system, with gargantuan growth on the supply side as we train more physicians, build more hospital beds and invent more expensive medical technologies, and with little, if any, resistance on the demand side.

The creation of this health care cost monster did not spring from the brain of some demented doctor. We all contributed mightily to the effort.

American businesses, experiencing high growth in the post-World War II period, had little concern as they expanded health care benefits. After all, health care seemed a lot less expensive to give employees than a higher per hour wage.

Unions demanded more health care coverage for their members, especially since health premiums were tax-free fringe benefits to workers. With each round of bargaining, managers who fought with other suppliers over the price of each nail or screw, and union leaders who negotiated for each half-cent an hour, kept adding health benefits to contracts without realizing that they were becoming hostage to costs beyond their control -- costs that over the long run endangered jobs and hobbled profits.

The government also made its contribution. When the Medicare and Medicaid programs were instituted in the 1960's, the government was preoccupied with improving access to health care for the elderly and the poor. So we paid the political price by simply superimposing those programs on the existing cost-based, fee-for-service system.

The doctors and hospitals initially resisted these government programs. But once the Congress legislated the fee-for-service, cost and cost-plus reimbursement system into them, the doctors and hospital administrators cheerfully joined in the creation of this swollen health care cost monster.

Lawyers, judges and juries fed this Frankenstein by malpractice litigation that established unpredictable and unrealistic standards of negligence and whopping judgments against doctors and hospitals who failed to run one test or another.

It didn't take long to recognize the dangers. In 1968, President Lyndon Johnson sent Congress a message on "Health In America" citing three major deficiencies with the structure of the health care market:

- "Health insurance plans [that] encourage doctors and patients to choose hospitalization even when other, less costly forms of care would be equally effective;"
- The fee-for-service system of paying physicians "with no strong economic incentives to encourage them to avoid providing care that is unnecessary;" and
- "Hospitals [that] charge on a cost basis which places no penalty on inefficient operations."

President Johnson asked for legislation to test new payment systems. Congress refused to act that year. And it has failed to act decisively since them, despite the repeated entreaties of every President since Lyndon Johnson.

The Chrysler Story

For the past two years, I have been serving as head of a special Committee on Health Care of the Chrysler Board of Directors created by Chairman Lee Iacocca. This is the only committee of its kind in American business. Its members, in addition to Mr. Iacocca and myself, are Douglas Fraser, former head of the United Auto Workers; Jerome Holland, former Chairman of the American Red Cross, and William Milliken, former Governor of Michigan.

At Chrysler, as we fought for survival, we had to address the cost of health care.

It has not been an easy task. In 1984 Chrysler's health care costs will exceed $400 million, making the Blues Chrysler's single largest supplier. That's more than $1.1 million each day. This year Chrysler's total health care bill (which includes Chrysler's Medicare payroll tax and a portion of the health insurance premiums of its suppliers) will exceed $550 for each car we sell. That's down somewhat from $600 a car last year -- not because inflation in health care costs has abated, but because we are selling more cars.

The cost of Chrysler's health care program (which covers employees, retirees and their dependents) grew from $295 per active employee in 1964 to some $5,700 per active employee today. Chrysler's overall health insurance premium jumped from $81 million in 1970 to $364 million in 1983. This year Chrysler must sell about 70,000 vehicles just to pay for its health care bills.

If something isn't done to reduce projected increases, Chrysler's health care costs could exceed $1 billion in 10 years, or $16,000 per active worker.

If we could hold Chrysler's 1984 projected health care costs to a growth rate even 50% greater than the Consumer Price Index, we could save $25 million this year. If Chrysler could reduce the rate of increase in its health care costs just one percent, Chrysler could save more than $400 million over the next ten years.

Excessive health care costs are eroding America's ability to compete with foreign companies. Mitsubishi Motor Corporation, a Japanese car manufacturer in which Chrysler has an investment, spends only $815 a year for an employee's health care costs while each employee pays approximately $374. Unlike Chrysler, Mitsubishi has no direct cost for retirees or their surviving spouses because of Japan's national health coverage. Chrysler's comparable cost per active employee is $5,700 -- four hundred percent higher.

That gap may well increase. The Japanese government is moving aggressively to control health care utilization by seeking a law to require a substantial co-payment for employees, beginning at 10 percent and rising to 20 percent.

What does Chrysler get for its health care dollar? A health care industry that is expensive, wasteful and inefficient. Let me share with you a few examples of what we are discovering as we analyze our own health care plan in depth.

- Among the Nation's Medicare recipients, a very common medical procedure is cataract surgery. The procedure takes about 20 minutes, and rarely requires a general anesthetic.

  The average opthamologist charge for this procedure in the Detroit area is about $2,000.

  If a doctor performed three of these procedures a day, four days a week, 42 weeks a year, he would earn more than $1 million, for less than 200 hours of actual surgery, and have a 10 week vacation to boot.

  Compare this with the typical charge of $1,500 for serious abdominal surgery lasting four to five hours.

- We asked some doctors to investigate eight Detroit area hospitals with extraordinarily high percentages of non-surgical admissions for low back problems.

  This study showed that two-thirds of the hospitalizations -- and 2,264 out of 2,677 of the total hospital days -- approximately 85 percent -- were inappropriate.

  With respect to three of the hospitals audited, none of the admissions were found to be appropriate.

  In more than 60 percent of the cases, patients were subjected to electromyograms -- an invasive and expensive procedure that is necessary only if surgery has already been clinically indicated. All the test results were normal.

  Had the inappropriate admissions not occurred Chrysler would have saved approximately $1 million.

- Our physician experts investigated the six Detroit area hospitals with the highest number of maternity admissions for our insured. In more than 80 percent of the 618 cases studied, one or more of the hospital days were found to be unnecessary -- a total of over 1,000 inappropriate days, almost a quarter of the time spent in the hospital.

  If the inappropriate days were eliminated in only those 6 hospitals, Chrysler would have saved $1 million.

We have no reason to believe that Chrysler's experience is unique. Similar waste and inefficiency exists in almost every health benefit program in this country. Chrysler's preliminary investigation suggests that as much as 25 percent of its hospital costs may be due to waste and inefficiency. For Chrysler, elimination of those costs would save almost $50 million in 1984.

Other studies have also found substantial evidence of inappropriate or unnecessary hospitalization. The Department of Health and Human Services sponsored a study of the appropriateness of hospitalization of Medicare patients in 1980. The study sample included 25 hospitals, urban and rural, from different regions of the country. It found that 20 percent of the hospital admissions were either unnecessary or premature. Most importantly, the study concluded that 27 percent of hospital days were medically inappropriate. If we reduced the number of hospital days expected in 1984 by 25 percent, we would save more than $60 billion -- without adversely affecting the quality of care.

Chrysler is not sitting still. In less than two years, we have acted to save nearly $10 million annually:

- We set up a screening program for foot surgery, which cut utilization 60 percent and saves over $1 million a year.
- We began a program to promote generic drugs which saves $250,000 a year.
- We mandated second medical opinions before certain elective surgeries, which saves $1 million a year.
- We instituted programs to encourage outpatient surgery, which save $2 million a year.
- We have started a new program in Michigan to screen hospital admissions and control lengths of stay for Chrysler's non-bargaining unit employees. We project a savings of $2 million in its first year. If we could extend this program to Chrysler's United Auto Worker employees, which would require union agreement, we estimate we could save $9 million in the first year.
- We offer financial incentives to encourage our employees to enroll in Health Maintenance Organizations.
- Just recently we offered our employees in Indiana and Michigan the opportunity to participate in Dental Health Maintenance Organizations. 11,000 employees and retirees joined and this will save us $2 million a year.
- We initiated a pilot incentive program, called "One Check Leads to Another," to encourage employees and retirees to review their medical bills for accuracy. Where they find overcharges, we share the refund with them. We hope this program will also lead to a greater awareness on the part of our employees of the costs of their health care services.

- We mounted an intensive communication program to educate both employees and health care providers about these new corporation initiatives and the cost of health care.

These steps are only the beginning. We are currently exploring several preferred provider arrangements, including programs for outpatient psychiatric services, laboratory tests, and prescription drugs.

In short, Chrysler is trying to do everything it can to control health care costs by eliminating waste and inefficiency. But Chrysler and American business cannot control health care costs alone. We need help to restructure the financial incentives in America's health care industry to eliminate its inefficiencies, and, where possible, to instill some marketplace discipline.

More than 60 percent of the costs of hospital care are paid by federal, state and local government. Unless public expenditures and federal and state cost containment measures are part of a national health policy, it is inevitable that cost shifting will occur.

Sleight of hand tricks do not reduce health care costs. Costs disappearing from the federal health care budget have a remarkable ability to reappear elsewhere in the system. In the case of many elderly patients, for example, the incentive in the Medicare DRG cap for early discharge of hospital patients translates into early admission to nursing homes. The federal government plays this shell game because Medicaid pays for most nursing home care, and the states pay half the Medicaid bill (while the federal government gets no state help in paying the Medicare bill).

Another variant of the health care cost shell game is the trend to ambulatory surgery that has caused an explosion of new investment in equipment and physical plant for outpatient surgery centers, without any concomitant reduction in hospital beds. As a result, hospitals continue to have the same high fixed costs, which must now be spread over fewer patients.

Rather than reducing the cost of health care by eliminating the inefficiencies and waste in the system, the Federal government and the states have thus far found it easier to refuse to pay their share, grabbing credit for reducing budget deficits, when they are only hiding the actual health care costs under another shell. Rather than attack the structural defects in the health care financing system, the Congress and the Administration have opted to impose a hidden tax on American business and American citizens. The federal government's "savings" are the increased costs for business and individuals.

Let me tell you what recent federal policy means to Chrysler.

In order to stave off bankruptcy in 1979, Chrysler had to shrink its active workforce. Chrysler now pays for health care for nearly as many retirees and dependents as active employees and their dependents. Moreoever, the retirees are aging, averaging almost 69 years and getting older. We have more than 14,000 retirees age 75 or older; 6,000 are 80 or older.

For its retirees, Chrysler pays for many health care services not paid by Medicare. Therefore, as Medicare seeks to ease its own financial crisis by shifting costs to the individual, if that beneficiary is a Chrysler retiree, we pick up the cost.

In 1965, a Medicare beneficiary had to pay the first $40 of a hospital stay, today that copayment is $356. Similarly, the daily copayment for long term hospital stays has risen from $10 to $89 per day (for the sixtieth to the ninetieth day of an admission). Chrysler absorbs 100 per cent of these increases. The latest increase in the hospital deductible alone will cost Chrysler approximately $1 million a year. Our citizens haven't saved anything. Our government has simply hidden the pea under another shell.

Here are some more examples of how the Great Health Care Cost Shell Game affects Chrysler:

- Hospitals in Michigan will shift $2 million in bad debts to Chrysler bills in 1984. Medicare and Medicaid do not permit hospitals to shift bad debts to them.
- The Michigan State Insurance Commissioner has charged private payers to help subsidize the costs of insurance to supplement Medicare coverage of senior citizens.
- The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) requires the employer's group health insurance to provide the primary coverage for

> employees and their spouses over age sixty-five. That provision does not save our people a single dollar. It simply shifts the pea from Medicare to the private sector. The cost to Chrysler is $1.4 million in 1983 and will increase annually. The cost to all U.S. businesses is over $1.5 billion.

Some of the proposals for rescuing Medicare are outrageous examples of the Health Care Cost Shell Game. For example, the proposal by the Advisory Council on Social Security to delay Medicare eligibility from age 65 to age 67 would cost Chrysler approximately $100 million over the next five years. Over the next ten years, the delay would cost American business and citizens some $75 billion. It would shift the cost personally to citizens not fortunate enough to have such coverage. And it would not eliminate a single dollar of waste or inefficiency in the health care system.

This Nation cannot afford further delay in establishing a national policy to address the health care cost crisis. The graying of America is forcing the issue, with an ever-growing population demanding more expensive high technology hospital care.

In 1940, roughly seven percent our our population was 65 or older. Today that proportion is about 12 percent. When the baby boom ripens into the senior boom in the first quarter of the next century, some 20 percent of our population -- about 60 million Americans -- will be 65 or older.

And the composition of our older citizens is changing. In 1940, less than 30 percent of our senior citizens were 75 or older. By the end of this century, almost 50 percent of those over 65 will be 75 or older.

It's not just that life expectancy is now 72 for a man and 78 for a woman. Far more important is that those who live to be 65 now have a life expectancy of 82.

The effect of the aging of our population on health care costs is sobering. The Congressional Budget Office now projects that Medicare's Hospital Insurance Trust Fund will go bust by the early 1990s.

Yet, the Hospital Fund crisis is only the tip of the iceberg. Many thoughtful Americans are deeply concerned about the frightening levels of unfunded pension liability in our country. The crisis in the Social Security system is the forerunner of far more serious financial crises as we face up to unfunded government and private sector pension liabilities that many fear approach $1 trillion.

But few Americans have even begun to think about the unfunded health care liabilities of our nation. As our health care costs increase and our population ages, the present, unfunded post-employment health care cost liability of the Fortune 500 American companies alone -- with about 15 million employees -- approaches $2 trillion. The total assets of those companies was only $1.3 trillion in 1982.

That unfunded liability number alone should make us all realize that in health care costs, we face the greatest financial and social crisis in this Nation's history.

Congress must begin to address the costs across the health care system -- not just the issue of federal expenditures, but the fundamental issue of how we can restructure the system to eliminate waste and inefficiency and contain future growth while continuing to provide high quality care for our citizens.

As a first step, we recommend that the Congress this year enact legislation to establish a National Commission on Health Care Reform, similar to the National Commission on Social Security Reform. The Commission's charge should be to develop a national health policy, and its membership should include representatives of all interested parties -- federal, state and local governments, business, and labor, senior citizens and junior citizens, lawyers, physicians, hospitals and health insurers. The Commission can provide a forum to develop a comprehensive strategy to reduce costs without reducing care. The Commission should be required to make its report to the Administration, the Congress and the American people within one year, so that the next Congress can act.

We must create an efficient health care delivery system. We can't keep going the way we are. We simply don't have the money.

That stark fact presages a terrifying triage for the American people, and a debate over euthanasia more searing than our debate over abortion. In "The Painful Prescription", a book just published by Henry Aaron and

William Schwartz at Brookings, the authors argue persuasively that, like Great Britain, we will soon ration health care in our country.

We always have had rationing, of course, related to individual economic wealth. But, with Medicare, the government becomes the rationer of health care for those who use and need the acute care system most. This role is reinforced by the fact that the Federal government funds 90 percent of all the basic biomedical research in America, and, together with state and local governments, pays most hospital bills.

Bluntly put, Uncle Sam will soon be playing King Solomon with your father and mother and mine, and with you and me.

We face a frightening specter in our nation as medical technology and spiraling costs combine to blur the lines in hospital rooms among natural death, euthanasia, suicide and murder.

Without the most energetic pursuit of efficiencies, we will soon face a world in which there is no kidney dialysis for people over 55, no hip operations (or artificial hips) for those over 65, a world in which eligiblity for expensive anti-cancer therapy will be based on statistical assessments of success, and key organ transplants will be severely limited to special cases of virtually certain recovery -- all as defined in pages and pages of government regulations.

What kind of a vision for the future is that? It's not a very pleasant one. But, in Great Britain, that future is now. That's just what they do today.

We in America are fortunate because we still have time to avoid that fate. We can learn from Britain's experience. We have a far more productive society. We can well afford to provide quality medical care to all. But we must have a coherent national health policy which will eliminate inefficiencies and reduce the cost of health care for our society as a whole.

These issues, which go to the very sanctity of human life, are what make these hearings so important and your responsibilities as legislators so special.

Senator JEPSEN. I thank you, Mr. Califano. Your reputation as a man who gets things done and gets right at the heart of things certainly is justified from your testimony, and while it's a little bit fresh, if I may, I'd like to pursue a couple questions and then get some additional perspective when Mr. Shelton discusses some of the Ford Motor Co.'s specifics on this.

You point out in Great Britain the rationing system already exists and suggest this could be the case in this country if we're not careful. Let me say first off that I hope we never see that day and I am willing to do everything to see that it doesn't happen here.

But my question is, do you believe that the rationing approach has come about in Great Britain because of the excessive government regulations, specifically the national health insurance system they have over there, or is it a more fundamental flaw in their health care delivery system?

Mr. CALIFANO. I think, Mr. Chairman, that it's come about because of the explosion of health care costs in Great Britain, which is just a few years ahead of us in that regard. Every country that's adopted a national health plan has basically taken the system as it existed and simply put the national health plan on top of it.

For example, in Great Britain, the doctors are on the government payroll and the government owns the hospitals. That happened because the British plan was put into effect just at the end and right after World War II and at that point in time the voluntary hospital system had collapsed in Great Britain. The hospitals were full of war casualties and the government was running all the hospitals and all the doctors were in the military and on the government payroll.

In Germany, when they put in a national health care system, the insurance companies were virtually in total control of the German health care system and their national health care system is run by the insurance companies. They have severe health care cost problems, but not as bad as Britain's.

In our country, when we adopted medicare and medicaid, the original proposals were to change the fee-for-service reimbursement system and to change the system of a cost-based payments of hospitals, but it wasn't possible to pass that legislation and, as you indicated in your opening statement, our focus was on access to health care. We were worried about giving elderly people and poor people access to health care and we didn't think about costs.

Just as a brief anecdote, I can remember a meeting with President Johnson and Wilbur Cohen and Larry O'Brien who was then the President's liaison to the Congress. The medicare bill was in the House Ways and Means Committee. We couldn't get it out. Wilbur Cohen, who was at HEW then, said—or Larry O'Brien said, "Mr. President, the only way we can get that out is to accede to the doctors and hospitals and retain the customary and reasonable charge payments and the fee-for-services and what have you." The President said, "How much will that cost?" Wilbur Cohen said, "About half a billion dollars a year." President Johnson said, "Only $500 million? Get it out."

And so I think it's more than that we haven't done anything to deal with costs and that Britain hadn't done anything to deal with costs. Then the British basically put a cap on it and said, "We will only increase health care payments by *x* percent." I don't know what it is today. When I was Secretary of HEW, it was about 3 percent. And as a result, this rationing system took place.

And I think costs will drive this country to a rationing system if we don't act to make a medical system more efficient.

Senator **Jepsen**. Do you think it's accurate to say that our Government has taken a very narrow view of health costs and they've pretty much focused in on medicare and medicaid rather than the broad brush look at it?

Mr. **Califano**. I do, Mr. Chairman. I guess if I had to say that there's a central thrust to Chrysler's view and my experience both in the Government and now in the private sector, it is that the health care system is like a pillow. The suppliers have control over where they will place costs and without competition, if you push down one part of a pillow, another part of the pillow goes up. And what happens when you put a cap on medicare is that the hospitals whether they follow the diagnostic related group limits or the number of medical procedures covered, they will start—and they have started shifting costs over to private insurers. That's why there's been such a rush—this year I think the States have passed 300 or 400 laws to deal with health care costs in one way or another because they are getting squeezed by costs shifts.

So I think it would be our hope that when the Congress deals with this and the administration deals with this, they take measures that will affect the entire health care system and that we have a national health policy in this country to deal with the cost problem.

Senator **Jepsen**. Just one quick last question and then we'll move directly to Mr. Shelton and then we will come back and the three of us can discuss this in depth after his presentation.

You mentioned that Mitsubishi pays $815 a year approximately for health costs compared to $5,700 a year that Chrysler pays. Is there any difference when you look at the benefits? In other words, do we get what is 400 percent more of the benefits in quality care?

Mr. **Califano**. No. I think in Japan the health care quality for the Mitsubishi employees is every bit as—the care and access to care is every bit as wide and as high quality as it is in the United States. I think it's comparable care. The different components in that system is the employee at Mitsubishi makes a substantial copayment of over $300 in effect per year. Our employees in the auto industry at Chrysler certainly essentially make no copayments.

Second, in the retirement phase there aren't these enormous gaps in coverage and in effect the national health care plan in Japan covers older people. I don't mean to imply that Japan is without its cost problems. They do have health care cost problems. Their costs are rising. Their hospitalization is rising. But they appear to be moving aggressively in trying to deal with it and it is part of the tremendous disadvantage that we have in competing with the Japanese and we can't deal with that disadvantage alone. Chrysler alone cannot deal with the costs it's paying for its employees. The Government has to act, too. We are ready to go. We're ready. We are trying, as Ford is trying—and I'm sure Mr. Shelton's testimony will indicate—but we can't do this job alone.

Senator JEPSEN. That's a good lead-in for our next witness. Chrysler says they can't do it alone. Ford Motor Co., Mr. Shelton, you may proceed. Your prepared statement will be entered into the record. You may proceed in any manner you so desire.

STATEMENT OF JACK K. SHELTON, MANAGER, EMPLOYEE INSURANCE DEPARTMENT, FORD MOTOR CO.

Mr. SHELTON. Thank you, Mr. Chairman.

Ford Motor Co. welcomes the opportunity to provide testimony before this committee and, as you recommended, will summarize the prepared statement.

Industry is aware and concerned about the rise in health care costs. In 1982, health costs as a percentage of GNP rose 10.5 percent, up from 9.8 percent in 1981. This 1-year increase of .07 of a percentage point of GNP is about the same as the increase for the 5-year period 1975 to 1980, and only slightly less than the increase for the 5-year period from 1970 to 1975.

It's estimated that in 1983 health care costs climbed to 10.7 percent of GNP. For the period 1970 to 1982, business health care costs increased more than twice the overall U.S. rate and well over three times the increase in GNP.

Health costs have become the fastest rising cost of doing business in America and business is picking up a larger share of the Nation's health expenditures every year.

Health care also has become a major cost of doing business in large industrial States such as Michigan. From 1966 to 1983, per capita spending on health care in Michigan increased 550 percent. This seemingly uncontrollable escalation in health costs is a serious problem for all of us—Federal, State, and local government, business, labor, and the general public.

For Ford Motor Co., automotive and related operations, health benefit costs in 1983 was $742 million, up about $250 million over the past 5 years. Health care costs for our employees, retires and their eligible dependents added about $300 to the cost of each vehicle Ford produced in the United States in 1983, well over twice the $130 per vehicle number just 5 years earlier.

While many factors contribute to the high cost of health care in this Nation, the most significant is the lack of appropriate incentives for consumers and providers to use health services in a cost-effective manner.

Getting health care costs under control will require the right incentives and more competition between provider groups and major insurance programs. These actions could include changing the traditional fee-for-service reimbursement system to one of capitation where services are provided for a single monthly fee with the provider accepting the risk for health services utilization and costs.

At Ford, our health care cost containment actions are governed by a philosophy that competition created by voluntary, private initiative offers the best opportunity for controlling costs in the long run.

Although under some circumstances there may be a need for Government to motivate private sector efforts, we believe regulatory approaches should be minimized and designed to promote, not impede, private sector initiatives.

Consistent with this philosophy, Ford has undertaken three approaches to the health care cost problem.

First, the company promotes changes in health financing that are designed to increase market competition and create financial incentives to contain costs. Examples include offering alternative health care delivery systems such as health maintenance organizations, or HMO's, inclusion of copayments in benefit programs, financial incentives to promote ambulatory surgery, and increased use of capitation-type and preferred provider arrangements.

Second, the company supports short-term programs designed to correct utilization problems caused by inappropriate incentives in the health system. Examples of these types of programs include various forms of utilization review, the second surgical opinion program, active support of State and local health planning efforts, improved administration of company health plans, and participation in business coalitions.

Third, the company promotes preventive health services designed to improve employee health status and reduce future demand. We believe most major improvements in personal health status can be best achieved through changes in personal lifestyle. Ford therefore promotes preventive and health education programs to minimize employee health risk factors and promote healthy lifestyles. For example, Ford's employee involvement teams developed and now run a fully equipped employee fitness center in Dearborn, MI. Aerobics classes are being test piloted in one of our plants, and other locations are offering programs such as smoking cessation programs and hypertension screening, substantive youth counseling and so forth.

Recognizing that the cost-inducing incentives of the existing system developed over many years, and that several years will be required to turn these incentives around, our efforts include a blend of programs; some are expected to have immediate results while others are geared to the long term. Where feasible, we promote greater price competition in the delivery of health services and the development of appropriate financial incentives for the consumer to demand care, the hospitals and physicians who provide it, and the insurance companies who finance it.

Returning to our first approach, promoting changes in health financing, I'd like to share with you Ford's experience with health maintenance organizations, HMO's.

At Ford Motor Co., HMO's are the cornerstone of our health care cost containment program. Presently 85 percent of Ford's employees are offered the HMO option through 34 HMO plans around the country. Steady enrollment increases since 1970 show that our employees are satisfied with the coverage they receive as HMO members.

In 1983, Ford saved an estimated $7 million in premiums through HMO enrollment of almost 19,000 employees or about 9 percent of those eligible. During our salaries employee open enrollment last November, HMO membership increased by 155 percent. Now 20 percent of salaried eligible employees nationally and 25 percent in Detroit belong to HMO's. This brought total enrollment for both hourly and salary employees to 28.000 in January 1984 or about 13 percent of those eligible. And I should mention that hourly employees are presently undergoing their annual open enrollment and we expect their participation to increase.

HMO's have a time-tested and consistent record of success. Most importantly, HMO's address the root causes of the cost problem. They reorganize the delivery system and place responsibility for cost containment with the group having the most control over costs, the medical provider.

For employers like Ford, with fully paid comprehensive health care benefits, HMO's offer immediate savings due to lower premiums. In 1983, Ford HMO premiums averaged about 16 percent below traditional plans. Those HMO savings and the potential for future savings are attracting the attention of management around the country.

HMO's also create cost competition within the health system. This competition usually takes one of two forms: One, competing providers and insurers develop their own HMO's; or two in an effort to maintain market share, traditional insurers become more cost conscious and implement needed cost containment programs.

Ford's involvement with HMO's is not new. We've dealt with them for over 30 years and our experience has been favorable. We believe HMO's favorably influence health costs and that they are an essential element of any business or community cost containment strategy.

Before concluding, I'd like to call your attention to one additional factor contributing to business costs problems and one which is growing in importance.

Recent Government policies to relieve its costs problems have resulted in shifting public health costs to the business community. Examples of such policies include making employer plans primary for certain instage renal disease and primary for health care for employees working between ages 65 and 69, creating reimbursement shortfalls for medicare and medicaid prospective payments, and increasing medicare copayments and premiums.

These policies represent a significant cost penalty to business and we urge that future payment reform avoid further cost shifts.

In summary, the bottom line is that business will be financing a larger piece of the expanding health cost pie. As a result, it must get more involved in becoming participating partners in determining future health policy. We believe voluntary private initiatives offer more hope for controlling costs in the long term than do regulatory approaches.

Under those circumstances where legislation becomes necessary to motivate private sector actions, we believe it should be structured to promote and not impede voluntary initiatives. We believe in the long term the best hope for containing health costs lie with programs aimed at increasing competition in the area of cost, quality, and access between major health systems and in modifying the demand for health services by changing the economic incentives of consumers and providers.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Shelton follows:]

PREPARED STATEMENT OF JACK K. SHELTON

INTRODUCTION

Mr. Chairman, my name is Jack Shelton. I am Manager of the Employee Insurance Department at Ford Motor Company and responsible for the financial administration of the Company's employee health insurance programs. I welcome the opportunity to provide testimony before this committee.

HEALTH CARE COST PROBLEM

Industry is aware and concerned about the rise in health care costs -- over the past 30 years, health care has become the fastest rising cost of doing business in America. From our viewpoint, present economic realities will force some major revisions in the way health care services are organized and financed.

The critical difference between today and past years is that, while the alarming trend of ever-increasing health care costs has continued during the last five years, business's ability to absorb these increased costs has changed. Higher health care costs have become increasingly difficult to recover in a marketplace plagued by uncertain, long-term growth prospects and increasingly intense competition.

NATIONAL PICTURE

I won't burden you with a lot of numbers to dramatize the problem, but I would like to focus briefly on a couple of "bottom-line" indicators. First, overall health care costs continue to increase at rates which to us are unacceptable - 1982 health cost as a percent of

GNP rose to 10.5%, up from 9.8% in 1981. This one-year increase of 0.7 percentage points of GNP is about the same as the increase for the five-year period 1975-1980 (0.9 percentage points) and only slightly less than the increase for the five-year period 1970-1975 (1.1 percentage points). Estimated 1983 health cost climbs to 10.7% of GNP.

Second, for the period 1970-1982, nominal growth in GNP increased by 208%, U.S. health expenditures by 332%, and business health expenditures by 700%. Business health care costs increased more than twice the overall U.S. rate and well over three times the increase in GNP. As these data indicate, every year business is picking up a larger share of the nation's health expenditures.

FORD PICTURE

More specifically, for Ford automotive and related operations, health benefit costs in 1983 were $742 million - up about $250 million over the past 5 years. This increase occurred without any major benefit change - and despite a substantial reduction in the number of employees and dependents covered under Ford health plans. Health care costs added about $300 to the cost of each Company vehicle produced in the U.S. in 1983, well over twice the $130 per vehicle 5 years earlier.

Health care and health care insurance also have become major costs of doing business in large industrial states such as Michigan. From 1966 to 1983, per-capita spending on health care in Michigan increased 550%. These costs have been rising much faster than general inflation. It is estimated that in 1981, Michigan employers spent $4.3 billion for employee health benefits, not including the share of public expenditures on health care that are financed in part through taxes on business. This seemingly uncontrollable escalation in health costs is a serious problem for all of us -- federal, state and local government, business, labor, and the general public.

To Ford Motor Company, as one of the nation's largest employers and a major purchaser of comprehensive health care services for over 800,000 active employees, retirees, surviving spouses, and their dependents, health care costs are a significant financial burden. This committee is to be commended for undertaking an analysis of this difficult and complex problem. Your deliberations and recommendations can provide important direction for initiating necessary changes in the health system. In my testimony this morning, I will review Ford Motor Company's philosophy and approach toward cost containment as well as present an overview of programs implemented over the years to address the cost problem.

BUSINESS RESPONSE

While many factors contribute to the high cost of health care in this nation, the most significant is the lack of incentives for consumers and providers to use health services in a cost-effective manner. Getting health care costs under control will require the right incentives and more competition between provider groups and major insurance programs. These actions could include changing the traditional fee-for-service reimbursement system to one of capitation where services are provided for a single monthly fee with the provider accepting the risk for health services utilization and costs.

Faced with high costs in a competitive economic climate, business is responding in a classical economic sense - it is becoming a more prudent purchaser of health benefits. It is attempting to develop more cost-effective payment arrangements with providers, to shift services away from the most expensive segments - like hospital care - and toward more appropriate, lower cost settings, and to stimulate competition and market actions.

FORD STRATEGIES

In response to rapidly increasing health costs, Ford has expanded its health care cost containment programs and increased its involvement with community efforts. Most of these programs have been initiated jointly with the UAW -- containing costs, while assuring quality and access to care, has long been a common goal shared by both business and labor. At Ford, our health care cost containment actions are governed by a philosophy that competition created by voluntary, private initiative offers the best opportunity for controlling costs in the long run. Although under some circumstances there may be a role for government to prod private sector efforts, we believe regulatory approaches should be minimized and designed to promote, not impede, private sector initiatives.

Consistent with this philosophy, Ford has undertaken three approaches to the health care cost problem.

First, the Company promotes changes in health financing that are designed to increase market competition and create financial incentives to contain costs. Examples include offering alternative health care delivery systems, such as Health Maintenance Organizations, or HMOs, inclusion of copayments in benefit programs, and financial incentives to promote ambulatory surgery.

Second, the Company supports short-term programs designed to correct utilization problems caused by yesterday's inappropriate incentives in the health system. Examples of these types of programs, which have become part of the Company's collective bargaining agreement with the UAW, include concurrent utilization review, surgical second opinion programs, and weekend admission reviews. Most of these programs are initiated in one location on a pilot basis, and those which prove to be cost effective are then expanded to additional areas. Ford also participates in several community efforts including board memberships on health planning agencies and other health care organizations, sitting on hospital boards of trustees, and serving on Blue Cross and Blue Shield Boards of Directors.

Third, the Company promotes preventive health services we hope will reduce future demand. We believe most major improvements in personal health status can be best achieved through changes in personal lifestyles. Ford promotes preventive and health education programs to minimize employee health risk factors and promote healthy lifestyles. For example, Ford Employee Involvement teams developed and now run a fully-equipped employee fitness center in Dearborn, Michigan where most of our employees are located. Aerobics classes are being test piloted in one of our plants, and some locations are offering smoking cessation programs.

Recognizing that the cost-inducing incentives of the existing system developed over many years, and that several years will be required to turn these incentives around, our efforts include a blend of programs; some are expected to have immediate results while others are geared to the long term. Where feasible, we promote greater price competition in the delivery of health services and the development of appropriate financial incentives for the consumers who demand care, the hospitals and physicians who provide it, and the insurance companies who finance it. However, we recognize that these changes will require time to implement. We, therefore, continue to support the need, in the short-term, for selective regulation - such as certificate of need and health planning - and for programs designed to correct specific problem areas.

MARKET INCENTIVES - INCREASED COMPETITION

Turning now to Ford Motor Company's specific program strategies, I will begin with those that have been designed to strengthen market competition.

PROMOTION OF HMOS

Over the past 50 years, the HMO industry has emerged from a history of slow growth to one of rapid expansion. It has, in the last ten years, grown from a movement of a few plans into a mature industry that has established itself as a cost-effective and high-quality health care delivery system. HMOs today serve over 12.5 million members. The rapid expansion of the HMO industry over the last ten years can be attributed in part to the increased interest and support of employers nationwide. This employer interest and support has grown over the years, and today industry is actively supporting the HMO concept by promoting employee enrollment, and in some cases, actually sponsoring an HMO.

The results speak for themselves. At Ford, HMOs are a cornerstone of the Company's health care cost containment program. Presently, 85% of Ford employees are offered the HMO option through 34 HMO plans around the country. Our employees are satisfied with the coverage as evidenced by steady enrollment increases since 1970, despite reductions in both hourly and salary employment. In 1983, Ford saved an estimated $7 million in premiums alone through the HMO enrollment of almost 19,000 employees or 8.7% of its eligible employees. During the most recent open enrollment period conducted for salaried employees, HMO enrollment increased by 155% bringing total salaried enrollment up to 15,000 or 20% of eligibles (25% in the Detroit area), and total enrollment (hourly and salaried) to 28,000.

HMOs have a time-tested and consistent record of success. Most importantly, HMOs address the root causes of the cost problem. They reorganize the delivery system and rest responsibility for cost containment with the group having the most control over costs, the medical provider. I believe HMOs offer advantages to employers, employees, and the community. Let's review these advantages each of which contributed significantly in our decision to support HMOs.

First, there are advantages to employers. Offering cost-effective HMOs results in immediate and direct savings due to lower premiums. This is especially true for employers like Ford with traditional comprehensive health care benefit packages and 100% employer payment of the premium. For 1983, HMO premiums for Ford averaged almost 16% below traditional plans. These HMO savings - and the potential for future savings - attracted the attention of our management and explain executive level interest in HMOs.

A second advantage is that HMOs create cost competition within the health system. This competition usually takes one of two forms: (1) competing providers and insurers develop their own HMOs, or (2) in an effort to maintain market share, traditional insurers become more cost conscious and implement needed cost containment programs. Although this ripple effect is difficult to document, a Federal Trade Commission report concluded that HMOs do elicit a competitive response - the most pronounced being reduced hospitalization by members of more traditional plans.

A third advantage of HMOs is the provision of more comprehensive benefits for employees along with improved health system access.

Some critics have suggested that self-selection may be an important determinant of differences in use and costs when comparing HMOs with traditional fee-for-service coverage. They argue that the cost differences between experience are due to adverse risk selection - that HMO enrollees tend to be healthier while sicker people, reluctant to establish new physician relationships, remain in traditional insurance programs. Research to date on the issue of self selection indicates selection can go either way depending upon variables such as the benefit package. We remain convinced that mature HMO programs are cost effective and do stimulate market reaction which benefit the Company, the employee, and the community.

Ford's involvement with HMOs is not new. We have dealt with HMOs for 30 years, and our experience has been favorable. There is a growing realization in industry that HMOs can favorably influence health costs and that they are an essential element of any business and community cost containment strategy.

PREFERRED PROVIDER ORGANIZATIONS

The advent of preferred provider organizations (PPOs) signals another important development, and promises to further the goals of increased market competition. Through the PPO, employers and other health plan sponsors are intervening to control the cost and quality of the health benefits they pay for. Under traditional insurance plans, employers have little direct relationship with health care providers. As long as the provider has the proper licenses and credentials, and as long as its services are eligible for coverage under the plan, the employer, either directly or through an insurance carrier, pays the bill without any real say in how care is delivered, and with little regard to the relative efficiency of existing providers.

PPOs, however, promise to change this. By instituting direct contractual relationships between and among employers, health care providers, and insurance carriers, the PPO creates an incentive to produce cost-efficient, quality health care service within more predictable parameters of expense and utilization.

While PPOs are a relatively new concept, they are receiving a lot of attention because they offer cost advantages to both employers and employees, as well as increase patient volumes for providers. The California PPO legislation was only the beginning of a new wave of

State legislative initiatives that will potentially encourage the development of selective provider networks based upon cost, quality, and utilization standards. It is important to note, however, that there is the risk that some states may develop restrictive PPO legislation. We will be following very closely the strategies adopted by others in implementing this new concept. Meanwhile, Ford Motor Company has already been approached by several local PPOs, and we are proceeding with a careful review. As health benefit cost pressures continue, it is likely that providers with unique, cost-effective PPO networks will find a receptive ear in the business community.

PROSPECTIVE PAYMENT SYSTEM

In 1978, Blue Cross-Blue Shield of Michigan, with strong encouragement from Ford Motor Company, established a hospital prospective payment system. Under this program, hospital budgets are approved on a prospective basis putting hospitals "at risk" for expenditures in excess of the budget. Hospitals receive an incentive if costs are reduced. Strong incentives are thereby created to reduce benefit utilization and cost. This voluntary program, established 5 years ago, has contained the maximum budget screen to under 10% for the past two years, a track record not matched by many similar programs mandated by State laws.

FINANCIAL INCENTIVES

The Company has also established financial incentives to encourage more appropriate service use. Pilot programs have been developed to encourage substitution of less costly outpatient care for inpatient care and to reduce the use of unnecessary or obsolete surgical procedures. Programs include an ambulatory surgery program which uses economic incentives/disincentives to encourage providers to perform surgery out of hospital and at lower cost settings, e.g., outpatient facilities or physicians' offices, and mandatory second opinion programs which require employees to obtain a second opinion as to the need for certain elective surgical procedures in order to receive 100% benefit. If second opinions are not obtained, benefits are paid at 80%.

BENEFIT DESIGN

Before going on to describe programs designed to correct certain structural utilization problems of the present system, I would like to spend a few minutes discussing the issue of benefit design. In February 1984, the Midwest Business Group on Health released its 1983 survey on innovative plan design. The 86 survey respondents covered over 1 million employees in the Midwest. In general, there appears to be significant evidence to indicate that employers are changing their philosophy of plan design and administration. Compared to the more traditional plans in use for many years, companies are attempting to eliminate the "blank check" to health care providers and employees by changing levels of copayments, premium sharing, and stop-loss. The assumption is that sharing in the cost of health care will prompt employees to use health services more responsibly. Increasing employee awareness of the high cost of medical care through cost sharing is clearly one part of the cost management strategy evident in many companies.

Proponents of cost-sharing argue that it curtails over utilization and restrains the purchase of care that yields little or no benefit. Opponents counter that, if people must pay out of pocket for medical care, their access to appropriate levels of care will decrease, and they will suffer accordingly. Recent findings indicate, however, that for most medical conditions, cost sharing does not increase costs in the long term by introducing delays in receipt of needed care resulting in more expensive hospitalization later.

Ford Motor Company has included cost sharing features in a number of its benefits -- for example, cost sharing in drug, dental, vision, and hearing plans. In addition, on January 1, 1984, Ford Motor Company implemented its new Comprehensive Medical Plan for salaried employees. This plan provides greater catastrophic coverage for employees and incorporates employee cost sharing with a maximum annual out-of-pocket employee expense of $750 for most hospitalization and professional services. This plan is designed to increase employee and provider cost consciousness and promote competition between other health plans, for example, HMOs.

Another plan design feature we are investigating closely is what we call "unbundling" of benefits. This means the separation of specific coverages or elements of coverage from our overall health care package in order to make special payment arrangements with providers of those services. For example, beginning in July of 1983, the Company offered its employees a mail-order drug plan on an optional basis. Under this program, employees using primarily maintenance drugs can - at their option with each prescription - have it filled through the mail at a reduced cost to themselves. This program offers greater convenience and lower cost to our employees as well as reduced overall cost to the Company. Earlier, in 1982, the Company began to provide incentives to pharmacies to dispense lower-cost generic drugs, rather than brand-name drugs.

Related to the unbundling of benefits is our increased use of capitation-type arrangements to deliver certain benefits such as dental, foot care, vision, and certain other professional services. We believe capitation-type arrangements, where all services are provided for a single monthly fee with the provider accepting the risk, may offer considerable opportunity for savings when compared to the usual fee-for-service arrangements. Our experience to date certainly confirms this - for example, the five dental capitation plans now in effect have saved several million dollars in premiums since their inception.

We expect to see positive changes in our local health care system as a result of the various programs I've described thus far. But, as I mentioned previously, we recognize it took many years to create the cost-inducing incentives of the existing system, and several years will be required to turn these incentives around. In recognition of that fact, Ford has also participated in activities and developed programs to support state and local health planning efforts, improve the administration of Company health plans, and increase consumer and provider awareness of the cost problem.

MARKET INTERVENTION

For example, in 1978, Ford worked with other business, labor, government, and provider interests in the development and passage of legislation to reduce surplus hospital capacity in Michigan. This legislation was enacted in response to pressure to contain costs within the private and public sector. It's an excellent example of public and private interests working together to address a difficult and complex system imbalance. Because of the uniqueness of the approach and the task, it is being followed closely by Federal officials. The bed reduction program, which was endorsed by the Michigan Hospital Association, provided for Health Systems Agencies to develop hospital-specific bed reduction plans. These plans have been approved by the Statewide Health Coordinating Council and future hospital construction projects are to be approved only if they are consistent with these plans. To facilitate this reduction process, the Company participated in the establishment of a private, non-profit corporation responsible for funding capacity reduction costs including expenses associated with the placement of displaced employees, and long-term debt of closed institutions. To date, nearly 50% of the beds targeted for removal have either been removed or committed to be reduced.

Ford Motor Company is now working with other state business, labor, consumer, and provider organizations to motivate hospitals and local planners to adopt a budget and financial planning approach to the review of competing hospital capital projects. We also are supporting efforts now underway to strengthen Michigan's Certificate-Of-Need law.

We have encouraged the development and implementation of programs to evaluate the necessity, appropriateness, and efficiency of medical services and facilities. These programs include concurrent and focus review (evaluation of hospital admissions and planned length of stay), retrospective review (after-the-fact evaluation of hospital admissions and length of stay), and professional review (pre- and post-payment review to identify and analyze unusual patterns of physicians' practice).

IMPROVED PLAN ADMINISTRATION

Internally, we have taken steps to improve the administration of our own health care plans by revising the provisions for coordination of benefits and by developing a comprehensive, computer-based, interactive medical claims data system. The Company has recently strengthened its coordination of benefits clause, a health benefit provision which applies when a patient is covered by two or more group health insurance plans to determine which plan pays first. The Company and the UAW worked closely with the National Association of Insurance Commissioners in changing guidelines for coordination of benefits to make coverages due to retirement or laid-off status secondary to coverages resulting from active employment. The Company is now working to implement these new guidelines in key plant states through legislation or other appropriate mechanisms.

This summer, the Company will be implementing a new health care claims data system through Medstat Systems, Inc. The new system will provide reporting capabilities to evaluate our health care plans, improve quality of carrier claims data, develop information for cost containment initiatives, and provide data for carrier cost performance evaluations.

Taking very seriously our responsibility to contribute to increased consumer and provider awareness of the health care cost problem, we have been a leader in developing coalition efforts nationwide. We helped establish the Washington Business Group on Health as well as the Michigan Health Care Cost Coalition, and helped many others get started. Among these are the Midwest Business Group on Health, headquartered in Chicago, and coalitions in Tennessee, Alabama, and California. Recently, we have been very active in health care initiatives sponsored by the Economic Alliance for Michigan. The Economic Alliance for Michigan is a private sector organization of about 80 business and labor leaders working to effect long-term changes in Michigan's business climate. Priority health activities are HMO promotion, support of hospital capital budget planning, and PPO legislation. Ford Motor Company also participates on various Blue Cross and Blue Shield boards and committees, is represented on state and national health committees, and contributes to national and state cost containment seminars.

PROMOTION OF HEALTHY LIFESTYLES

I would like to share with you one other strategy adopted by Ford in recent years to promote cost containment and improve the health status of our employees. I am referring to our interest in health promotion and preventive health services. Since the early 1970s, our Employee Health Services Department has developed and implemented several programs in the area of cardiovascular risk intervention, hypertension screening, alcohol and drug abuse counseling, smoking cessation, and cancer screening. A three year program conducted in four plants demonstrated that it is feasible and practical to conduct a successful program in hypertension identification and follow-up.

Program evaluation was completed in cooperation with the University of Michigan and funded by the National Heart, Lung, and Blood Institute. While it is difficult to prove these programs are cost beneficial, we believe they're the right thing to do. We are highly supportive of these programs and anticipate significant long-term savings with respect to employee well-being.

COST SHIFT TO THE PRIVATE SECTOR

Before concluding, I would like to call to your attention two additional factors contributing to the business cost problem which are growing in importance. First, is the cost shift between public and private health programs. Recent government policies have resulted in shifting public health costs to the business community. Examples of such policies include: making employer plans primary for certain end-stage renal disease expenses and primary for health care for working employees between 65 and 69 years of age, creating reimbursement shortfalls from Medicare/Medicaid prospective payments, and increasing Medicare copayments and premiums. These policies represent a significant cost penalty to business, and we strongly urge that future payment reforms avoid further cost shifts.

The other factor motivating continued business concern with health costs is the aging and maturing of the workforces of major manufacturing industries. For many industries, the ratio of insured to working employees has increased dramatically. For example, between 1970 and 1978, for every two working employees insured by Ford, there was an average of one person insured who was not working. Last year, this ratio was close to one-to-one - for every person working there now is one other person (and their dependents) who have full health coverage even though they are not working. This ratio results in a signficant fixed cost burden on working employees who make the Company products which produce the revenues to pay these health costs.

CONCLUSION

The bottom line to all these trends is that business will be financing a larger piece of the expanding health-cost pie. As a result, it must get more involved and be a larger partner in determining future health policy.

We believe voluntary private initiatives offer more hope for controlling costs in the long term than do regulatory approaches. Under those circumstances where legislation becomes necessary to prod private sector initiatives, we believe it should be structured to promote, and not impede, voluntary initiatives.

We believe, in the long-term, the best hope for containing health care costs lies with programs aimed at increasing competition in the areas of cost, quality, and access between major health systems and in modifying the demand for health services by changing the economic incentives of consumers and providers.

Senator **Jepsen**. Thank you, Mr. Shelton.

Referring to your last summary statement with regard to the change adopted a few years ago which made the employer a payer of first resort for employees age 65 to 69, is it your contention that despite the fact that these people remain productive workers for Ford that Ford should no longer consider them in the same category as other Ford employees just because they do meet the qualifications for the medicare program with their health care coverage?

Mr. **Shelton**. We estimate that this change added about $3.3 million to our costs just for the coverage for the people between 65 and 69 and that does not include the medicare taxes that the company has paid over the active work life of the employee prior to that time.

Senator **Jepsen**. Well, I appreciate that. I guess I'm just trying to explore it. Let's pretend for 1 minute that we have a person who has become 65 and stays on and works through age 69, a full-time productive employee. Is it your contention that at age 65 they should go to the Government provided insurance or rely on that rather than the company's insurance, even though they are full-time employees of the company?

Mr. **Shelton**. Well, the company prior to the change provided what's called complementary or wrap-around coverage. It supplemented the medicare program. When employees who continue beyond age 65 are no longer covered by medicare, that becomes a form in a sense double taxation to the employer who has been paying the tax during the working period of the employee and now must continue to provide full coverage.

Senator **Jepsen**. I'm not debating it. I just wanted to get your expression. Do you have any comment, Mr. Califano?

Mr. **Califano**. Mr. Chairman, I think the point that I would try to make there is that shifting that cost of covering an employee during whatever period of time from the Government to a corporation or from the Government to the employee himself or herself doesn't achieve anything in terms of a more efficient health care system. We're all still bearing the same burden. Instead of my paying it in taxes to the Federal Government and having the Federal Government be the cashier for the health care industry that is wasteful and inefficient, I'm paying it to the Ford Motor Co. in the price of the car I buy and the Ford Motor Co. becomes the cashier for the health care industry turning it over to them.

When we talk to Chrysler about a national health policy, we are saying that we've got to deal with the underlying problems and not just play the shell game. It's that part of it that I think we object to, not the coverage for the employee. The employee should be covered. The health care benefits should be provided, but we can provide the kind of health care these employees need at far less cost to all of us. We're all paying. The only difference is whether the person that shovels the money to the hospitals and the doctors and the laboratories is an intermediary vehicle or somebody in the comptroller's office in the Chrysler Corp.

Senator **Jepsen**. Well, we're working with mirrors. It depends on who's holding the mirror.

Mr. **Califano**. That's right, Mr. Chairman.

Senator JEPSEN. There's little argument in the cost shifting you mentioned plays a significant role in increasing the cost of health care in the private sector and that's something, among many other things, that we want to make sure that we do get out in the open, so to speak, with some perspective and understanding.

You talked a lot about the HMO's, Mr. Shelton. That's the health maintenance organizations. You mentioned in your testimony that Ford has seen significant increase in the number of employees who choose to participate in health maintenance organizations, HMO's.

To what do you attribute this move to and does this move tend to fall along generational lines? In other words, we have found that the younger folks talk about health maintenance and the more senior citizens tend to lean on the more traditional health care delivery procedures. Is this what you've found?

Mr. SHELTON. Certainly that happens. I think, in addition, HMO's are now better understood by employees and more importantly by their families. Therefore, they are more willing to move into these programs.

In addition, HMO's offer employees and their dependents broader coverage and less out-of-pocket expense than does the traditional fee-for-service program.

I think those are the two motivating factors, plus the one you mentioned.

Senator JEPSEN. Now as you may or may not know, I have a background in insurance for a quarter of a century and I've dealt with this so I have some familiarity with that with a company that did a lot of work—I'm no longer with them so there's no use in advertising, but it was Connecticut General, who is reasonably well-known and respected in the field.

As one who's fairly familiar with the way insurance programs work, I can see where this trend might have a serious impact on the beneficiary pool and how it may ultimately affect rates. Has your company attempted to determine the changes and breakdown along generational lines and, if they are, how is it going to alter the rates of those who live longer and your obligation on out the line who retire? Something that comes to mind is a little bit of this in the health insurance area comes in the front end and comes out and is paid for benefits that turn mover off down at the other end. Has that been a factor? Is yours self-funded?

Mr. SHELTON. Our programs are primarily Blue Cross and Blue Shield, with the exception of the HMO programs. But because of our size, we would be very close to being self-funded, although we're not.

Senator JEPSEN. I also note that many of the things that you indicate Ford was doing and other businesses are doing with regard to health care cost containment by way of getting people to better understand this, both of you referred to the need for education and better understanding. If they understand it, they appreciate it from the company standpoint and then you get that extra value, that extra loyaly, that extra productivity and it can be created by head power and heart power.

But even more importantly today, I think as we're here today trying to get a better understanding of the total health care picture in the country and how the various sectors of our economy and parts of our society, whether it be Government, the private sector, or business, the consumer, providers—where each of them fits into this picture.

Do you have any suggestions? I'm interested in knowing what Ford is doing to educate its employees totally in their program and what do you see that could be done by way of expanding that education outside into the community and into Washington, DC.

Mr. SHELTON. Well, certainly employees and their families education is extremely important. I have to confess that we have not done as good a job of that as we should have done, but we plan to enhance our efforts in the future. We do have regular stories that we run in our employee publications on health issues and we plan to intensity those activities in the future. We've had meetings with our salaried employees on the new salary health plan and we plan to continue those meetings in the future.

In addition, we have had some health education efforts with the employee involvement groups that we formed in the plant areas and throughout the company. So we are intensifying our employee education effort and I agree with you that that is a very important area and one that we have not worked as hard at in the past as we should have.

Senator JEPSEN. Mr. Califano.

Mr. CALIFANO. Chrysler is doing the same thing. I think we have to recognize that the payoff there is very real and very important. Probably the worst offender, Mr. Chairman, in terms of allocation of resources to health promotion and disease prevention is the National Government. The National Government spends 96 to 98 percent of the money is spends on health care on care and research, and less than 4 percent, probably somewhere between 2 and 3 percent now, on health promotion and disease prevention.

When you think that probably the most significant reasons of why we're having the change with respect to males in terms of cardiovascular disease is the fact that men are cutting down smoking, they're stopping smoking, there are fewer people smoking, and changing their eating habits, you can see why what a phenomenal impact that can have. Alcohol is the No. 4 disease in the United States of America now, behind cardiovascular disease or cancer and respiratory diseases, and that's all a function of what the individual does.

Fifty years ago the problems were dirt and the sewers and sanitation and pasteurizing milk and immunizing people. Now the problems are what we ourselves do to ourselves and I think there the Government should make a tremendous investment, as well as Chrysler. Chrysler stepped up its investment, as I think probably every American company has, but we've hardly begun in that area.

Senator JEPSEN. That certainly was a hallmark of your term of duty and service here and I commend you for it. You moved out and took some steps where others had kind of hesitated to tread before and that's much to your credit. It must be somewhat gratifying to see some of the results and people now are doing things that are commonplace that at that time was something they shied away from.

Mr. CALIFANO. Thank you, Mr. Chairman.

Senator JEPSEN. You suggested, Mr. Califano, that formation of a national commission on health care reform is a starting point for the development of health policy and you used the National Commission on Social Security as an analogy.

As I recall, one of the major stumbling blocks that commission had was coming to an agreement as to the magnitude of the problem. Do you think it's feasible to presume we would be able to get some kind of concrete recommendations out of this type of commission in a 1 year's length of time or would you expand on your thoughts on this commission? You talked about the makeup. How long do they need? What do they need to facilitate the goal? What can and should the tax dollar versus the private dollar—what role should it play, a joint one? Either one of you, I'd appreciate your comments.

Mr. CALIFANO. Mr. Chairman, I guess in terms of that commission, I think that the reason we need something like that and the reason we need to have all the players in the private sector involved as well those who run the health care programs for the Federal Government or the State governments is because we really are in a system which is just outside of anything like the regular great American free market system.

The doctors who order the tests don't pay the bills. Nobody says I'd like to buy an appendectomy today or a hysterectomy tomorrow. The patients don't have any sense of paying bills, particularly hospital bills, because 94 percent of those are paid for by medicare, medicaid, the Blues, or private insurers, and most doctor bills are not paid by the third parties. And in the system it's very easy to shift charges from one patient to another, one buyer to another, one hospital to another. So I don't think there are bad guys and good guys in this problem. I think everybody is acting just the way the economic incentives are encouraging them to act.

The more services a person is paid on a fee-for-service basis he performs, the more money they're going to make. The same thing is true with respect to hospitals, and the cost and cost-plus system.

I think that if you put all these people around the table and I think they will be able to determine how serious this problem is. One only has to look at this morning's newspaper. There's a story in the Wall Street Journal about the question with kidney transplants and vital organ transplants now. It used to be who lives, as the Wall Street Journal put it this morning. The question used to be in America, if we needed a vital organ transplant, who lives? The question today in these United States is, who pays? And in the Washington Post or the New York Times there are long stories about a group of distinguished doctors trying to figure out what the standards should be for physicians and patients in terms of expensive technology care for people who are very old or terminally ill. So these issues are on the front burner.

Can it be done in a year? I suggested a year in this testimony because I think the political realities for health care, like the political realities for Social Security, are that much sounder legislation will come out of Congress if the issue is voted on and legislated in a nonelection year. If it's not acted on in 1985, my instinct is that it won't be acted on effectively until 1987.

Now it may take longer because the Social Security crisis was in some way easier to measure. There have been years and years of agitation on the crisis in Social Security and there may be a lag time here, but I think the problem is so critical that it really behooves all of us to try and deal with it and to act on it. I think we are all, as you said, we've met the enemy and they are us. Well, everybody that is part of that problem should be put around that table to deal with it and you can't deal with it in the Federal Government alone. We are seeing cost shifting that I think we're only beginning to appreciate the impact of. We could have fantastic increases in private insurance rates at the end of next year over this year just because the only cap that's now in place is the medicare cap on 467 hospital procedures. Now there's an attempt in the House to try and freeze the fees for physicians, but I really think over the long haul, having both been a regulator and unregulated, that over the long haul, if we can get the incentives changed in this system, it will be far more effective.

Senator **Jepsen**. Do you have any comment, Mr. Shelton?

Mr. **Shelton**. No.

Senator **Jepsen**. Well, I thank you both. As you may know, we have a very aggressive preadmission screening program in Iowa which is utilized by the private sector as well as the medicare program. Right now they're being too aggressive. We've seen a tremendous decline in overutilization in Iowa. We've also received a number of complaints from both doctors and patients that people feel they are not getting health care, but we've had a very remarkable result in that Blue Cross in Iowa just recently asked for a $24 million rate reduction. This is the first such request in their history. So the consumer is realizing the financial benefit from this process and at the same time it is rather arbitrary and judgmental at this point. In fact, there is less accessibility of quality health care, but the consciousness is being raised or has been raised in all this and that's something you've been alluding to today here also, that we need to form the national health policy on the basis of consensus. We should formulate most or all of our policy on consensus rather than conflict or rather than the shell game as you pointed out, and I would expect that we could that.

I think your year recommendation sounds right because I think most of the motion, and I might add politics, that were involved in the Social Security repairing job sort of broke the way, so to speak. The commission came, it listened, it recommended, it proposed, and the Congress, because of the bipartisan approach and the people that were on it, together, both Republicans and Democrats—not everyone liked everything about it—but they went about the job of doing the things that needed to be done. I think that bodes well for the health care policy. I think a lot of the signposts that were set up have pointed in the right direction as a result of that commission's work and will now serve well in what you recommend here. It's interesting.

Mr. **Califano**. Mr. Chairman, I was out in Iowa at Des Moines last year at the Blue Cross-Blue Shield Cost Containment Conference, and was enormously impressed with the way that organization and Iowans basically generally—they're ahead of most of the country in your State on this problem.

Senator **Jepsen**. I thank you both for coming and look forward to participation and consultation and recommendations as we move along.

Now I would call Mrs. Bert White of the American Farm Bureau, James Hacking, and Willis Goldbeck. Mrs. White is currently serving on the board of directors of the American Farm Bureau Federation and will be testifying on their behalf. Welcome, Mrs. White. Mr. Hacking is assistant legal counsel for the American Association of Retired Persons, and will be testifying on behalf of AARP; and Willis Goldbeck, Washington Business Group on Health. Mr. Goldbeck is executive director of WGBH—not a radio station but the Washington Business Group on Health, made up of major employers from throughout the country. Between 200 and 300 companies are active members.

Mrs. White, Mr. Hacking, Mr. Goldbeck, welcome and we will start with Mrs. White.

STATEMENT OF MRS. BERT WHITE, CHAIRMAN, FARM BUREAU WOMEN'S COMMITTEE, AMERICAN FARM BUREAU FEDERATION

Mrs. White. Thank you, Mr. Chairman. I'm here today as chairman of the American Farm Bureau Women's Committee and member of the AFBF board of directors. My husband and I farm approximately 500 acres and raise Hereford cattle near Bailey, MS.

I would like to also add that I serve on the local hospital board.

Mr. Chairman, rising health care costs place severe stress on the pocketbooks of all Americans. No group is more aware of the financial grip of health insurance than self-employed individuals, particularly farmers. Together with employees who do not receive employer-financed health insurance, the Nation's 7.8 million self-employed business people must confront the serious inequity that exists in the use of income tax deductions to subsidize health insurance for other groups of workers.

While the Internal Revenue Code permits an employer to deduct employee health insurance premiums as a business expense—IRC 162—and treats the premiums as a tax-free fringe benefit to the employees—IRC 106—this type of tax treatment is not available to the self-employed worker who gets no writeoff, but who must then buy health insurance with after-tax dollars. Currently, the only way a self-employed individual can deduct any amount of health insurance costs is if the premium is included in an aggregate of itemized medical expenses constituting more than 5 percent of adjusted gross income.

The denial of a deduction is apparently because health insurance is considered a personal expense rather than a business expense. Farmers and ranchers disagree with this shortsighted reasoning. Farmers, like other self-employed small business people, conduct business activities both as employers and employees. The work environment of a farmer is often hazardous and not infrequently presents danger to life and limb from the use of heavy equipment and chemicals. Insurance is necessary to cover the costs of unexpected injury and illness stemming from the farming occupation. It is a cost of doing business that farmers cannot be without. We believe it is a reasonable request that a self-employed person be able to deduct his or her insurance premium as a business expense.

There is also a question of equitable tax treatment among farmers who have different business organizations for their farming operations. A farmer, who is a sole proprietor or in a partnership, cannot deduct the cost of health insurance premiums as a business expense. However, if the farm is incorporated, the farmer can be classified as an employee of the farming corporation. The corporation, as the employer, can deduct the cost of health insurance as a business expense, and the farmer, as the employee, can receive the health insurance tax free.

The committee will be interested in the amount of health insurance premiums that farmers pay. In Iowa, for example, the 1983 monthly cost of comprehensive major medical group plan insurance with no deductible was $84.15 for a single person and $185.27 for a family. This equals $1,010 and $2,223 on an annual basis. In Michigan, where age and area ratings apply, the annual family rate premium, zero deductible, was $1,902 in outstate areas for insureds under age 45. The annual cost jumped to $2,827 for those between 45 and 54 and to $3,117 between 55 and 64. In the farming areas adjacent to Michigan metropolitan areas, the same coverage was $2,551, under 45; $3,790, 45 to 55; and $4,180, 55 to 64. Even plans with deductibles are expensive. For instance, the 1983 family rate in Kansas for insureds aged 40 to 44 with a $600 deductible was $778.

The rates illustrate the high out-of-pocket cost that farmers pay. Remember that they take no deduction for this cost although their in-town neighbors who work for a business that provides health insurance can receive the same coverage tax free. Also, bear in mind that the Tax Equity and Fiscal Responsibility Act eliminated the $150 deduction for health insurance premiums that all taxpayers could have applied against the cost of their health insurance premiums.

The farm bureau recognizes that the Joint Economic Committee has no jurisdiction over specific legislation. However, we draw the committee's attention to two bills, H.R. 3487 and S. 2353, that allow the self-employed to deduct one-half of health insurance premiums as a business deduction. Farm bureau members across the country are working hard to gather support for these bills as well as others that would eliminate the inequity that exists in the tax treatment of health care insurance.

Mr. Chairman, the farm bureau is also actively supporting changes in the medicare program. One of the biggest misconceptions the public now has about medicare is that it covers all of the elderly's medical expenditures. This is an illusion. In actuality, medicare covers only 44 percent of the elderly's costs and only 30 percent of physician costs. This stems partially from the fact that a physician is free to charge a medicare patient whatever fee he determines reasonable for the service rendered. Medicare, on the other hand, also sets what they determine to be a reasonable fee. Usually, there is a wide discrepancy between the two definitions of reasonable. Present law requires a 80–20 copayment between medicare and the patient. This means medicare pays the physician 80 percent of what medicare believes to be a reasonable fee and the patient is responsible for their remaining 20 percent. The problem then arises as to the difference between what medicare determines reasonable and what the physician determines reasonable. This amount must also be paid by the patient and is the major reason that only 30 percent of physician's cost are actually paid for by medicare. Often obscured in the medicare debate is the cost shifting of medicare health benefits to private insurers and individuals. This should be noted.

Congress requires hospitals, nursing homes, and home health agencies to accept medicare reimbursement as payment in full. Farm bureau supports the idea of requiring physicians to accept assignment in all cases as a precondition to treating medicare patients. We recognize the argument that some doctors may choose not to treat medicare patients. Due to the fact that the elderly now represent 35 percent of the average caseload and due to ethical standards, we believe that most physicians will treat medicare patients. We also recognize that patients not covered by medicare will be paying higher costs for medical services as well as higher medicare taxes.

Mr. Chairman, I want to conclude this morning by assuring you that farm bureau does not feel we can rely solely on the Congress or the Government to solve our health care problems. We have tried to develop programs within our own organization to help solve these problems.

The American Farm Bureau Federation has had a nine-member rural health advisory committee in existence for the past 3 years. We also enlist the services of a seven-member professional advisory group. Twenty-five State farm bureaus will have advisory committees actively involved in programs by the end of this year, 1984. These committees give direction to negotiations for health insurance contracts covering memberships and to programs and activities to increase member understanding of health care costs and ways to reduce them.

Volunteer member support is evidenced by the number of programs and activities in which the members participate at county and State levels. In the past 2 years, more than 250.000 individuals were tested for high blood pressure at farm bureau functions. Farm bureau received national recognition for the efforts of this program and others.

Mr. Chairman, it's been a privilege to come here before this distinguished group and you and ask for the consideration of your committee. We assure you that farm bureau will continue to do whatever they can to eliminate these problems. Thank you very much.

[The prepared statement of Mrs. White follows:]

PREPARED STATEMENT OF MRS. BERT WHITE

Mr. Chairman, I am Bert White. I am here today as Chairman of the American Farm Bureau Women's Committee and a member of the AFBF Board of Directors. My husband and I farm about 500 acres and raise Hereford cattle near Bailey, Mississippi.

The American Farm Bureau Federation is the nation's largest general farm organization with a membership of over 3.3 million families in 48 states and Puerto Rico. Policies of the American Farm Bureau Federation are determined annually after being studied, debated and approved by a majority vote of its members at county, state, and national Farm Bureau meetings. The issue before this Committee is of great concern to Farm Bureau members.

Mr. Chairman, rising health care costs place severe stress on the pocketbooks of all Americans. Much has been written about the individual, as well as national, crises that have arisen from expensive health care coverage. While much of the media attention has been directed toward the exhorbitant expense of sophisticated medical technology, fees of health care professionals, and the high cost of hospitalization, very little has been said about the steadily rising cost of health insurance. This cost has increased despite the use of higher deductibles and decreased coverage.

Farm Bureau recognizes that the basic economic problem in rising health care costs is that the industry has shifted from one in which the private sector accounted for three-fourths of all health care costs to one in which the government -- federal, state and local -- now accounts for 43 percent of all health care expenditures.

No group is more aware of the financial grip of health insurance than self-employed individuals, particularly farmers. Together with employees who do not receive employer-financed health insurance, the nation's 7.8 million self-employed business people must confront the serious inequity that exists in the use of income tax deductions to subsidize health insurance for other groups of workers.

While the Internal Revenue Code permits an employer to deduct employee health insurance premiums as a business expense (IRC 162) and treats the premiums as a tax-free fringe benefit to the employees (IRC 106), this type of tax treatment is not available to the self-employed worker who gets no write-off, but who must then buy health insurance with after-tax dollars. Currently, the only way a self-employed individual can deduct any amount of health insurance costs is if the premium is included in an aggregate of itemized medical expenses constituting more than five percent of adjusted gross income (IRC 213).

The denial of a deduction is apparently because health insurance is considered a personal expense rather than a business expense. Farmers and ranchers disagree with this short-sighted reasoning. Farmers, like other self-employed small businesses people, conduct business activities both as employers and employees. The work environment of a farmer is often hazardous and not infrequently presents danger to life and limb from the use of heavy equipment and chemicals. Insurance is necessary to cover the costs of unexpected injury and illness stemming from the farming occupation. It is a cost of doing business that farmers cannot be without. We believe it is a reasonable request that a self-employed person be able to deduct his or her insurance premium as a business expense.

There is also a question of equitable tax treatment among farmers who have different business organizations for their farming operations. A farmer who is a sole proprietor or in a partnership cannot deduct the cost of health insurance premiums as a business expense. However, if the farm is incorporated, the farmer can be classified as an employee of the farming corporation. The corporation, as the employer, can deduct the cost of health insurance as a business expense, and the farmer, as the employee, can receive the health insurance tax-free.

The vast majority of farms in this country are operated as sole proprietorships. The 1978 Census of Agriculture indicated that 88 percent of all farms with sales of $2,500 or more were sole proprietorships, 10 percent were organized as partnerships, and 2 percent were incorporated. These figures translate into approximately 2.14 million sole proprietorships operated by farmers.

The Committee will be interested in the amount of health insurance premiums that farmers pay. In Iowa the 1983 monthly cost of comprehensive major medical group plan insurance with no deductible was $84.15 for a single person and $185.27 for a family. This equals $1,010 and $2,223 on an annual basis. In Michigan where age and area ratings apply, the annual family rate premium ($0 deductible) was $1,902 in outstate areas for insureds under age 45. The annual cost jumped to $2,827 for those between 45-54 and to $3,117 between 55-64. In the farming areas adjacent to Michigan metropolitan areas, the same coverage was $2,551 (under 45), $3,790 (45-55), and $4,180 (55-64). Even plans with deductibles are expensive. For instance, the 1983 family rate in Kansas for insureds age 40-44 with a $600 deductible was $778.

The rates illustrate the high out-of-pocket costs that farmers pay. Remember that they take no deduction for this cost although their in-town neighbors who work for a business that provides health insurance can receive the same coverage tax-free. Also, bear in mind that the Tax Equity and Fiscal Responsibility Act eliminated the $150 deduction for health insurance premiums that all taxpayers could have applied against the cost of their health insurance premiums.

We believe that the following arguments support a legislative remedy to this problem:

EQUITY

As previously mentioned, the federal government is subsidizing health insurance for taxpayers receiving employer-financed health insurance at the expense of two other groups of taxpayers who cannot tax advantage of current tax code provisions: (1) Self-employed taxpayers such as farmers and, (2) Employees who must buy their own coverage.

Even if Congress restricts the current tax-free status of employer-financed health insurance, the inequity will remain. Those employees currently receiving such benefit will continue to receive a certain level of coverage tax-free since all or a portion of the coverage will fall below the tax threshold amount of $840 per individual or $2,100 per family as proposed by the Administration.

PRECEDENT

The Social Security Act amendments of 1983 took a step to help achieve equity between employers and the self-employed in Social Security tax treatment. The new law provides that self-employed individuals will be able to take a tax credit for 1984-1989 against the self-employment tax that they must pay. After 1990, a new system of income tax deductions will be available to self-employed taxpayers. The deduction will be equal to one half of the amount of self-employment taxes paid for the taxable year.

A deduction or credit for the cost of health insurance premiums could be patterned after the credits/deductions enacted in the Social Security legislation.

RISING HEALTH CARE COSTS

Much has been said about the issue of health care insurance for the unemployed. The employed, as well as the unemployed, are hurt by rising health care costs, particularly those in hazardous occupations such as farming who may pay higher premiums because of higher risks.

HIGHER TAXES COMPOUND CASH FLOW PROBLEMS FOR FARMERS -- HEALTH INSURANCE DEDUCTION COULD HELP EASE THE PROBLEM

Farmers have been hit recently with higher Social Security taxes, gasoline taxes, and excise taxes. Such a deduction would ease the increasing tax burden on self-employed people, help compensate for direct, out of pocket expenses for health insurance, and lead to more equitable tax treatment of health care coverage.

Farm Bureau recognizes that the Joint Economic Committee has no jurisdiction over specific legislation. However, we draw the Committee's attention to two bills, H.R. 3487 (Latta; R, Ohio) and S. 2353 (Grassley; R, Iowa), that would allow the self-employed to deduct one half of health insurance premiums as a business deduction. Farm Bureau members across the country are working hard to gather support for these bills as well as others that would eliminate the inequity that exists in the tax treatment of health care insurance.

Mr. Chairman, Farm Bureau is also actively supporting changes in the Medicare program. One of the biggest misconceptions the public now has about Medicare is that it covers all of the elderly's medical expenditures. This is an illusion. In actuality, Medicare covers only 44 percent of the elderly's costs and only 30 percent of physician costs. This stems partially from the fact that a physician is free to charge a Medicare patient whatever fee he determines reasonable for the service rendered. Medicare on the other hand, also sets what they determine to be a reasonable fee. Usually, there is a wide discrepancy between the two definitions of reasonable. Present law requires a 80-20 copayment between Medicare and the patient. This means Medicare pays the physician 80 percent of what Medicare believes to be a reasonable fee and the patient is responsible for their remaining 20 percent. The problem then arises as to the difference between what Medicare determines reasonable and what the physician determines reasonable. This amount must also be paid by the patient and is the major reason that only 30 percent of physician's cost are actually paid for by Medicare. Often obscured in the Medicare debate is the cost shifting of Medicare health benefits (costs) to private insurers and individuals.

I should point out that only 52 percent of physicians are willing to accept Medicare payment as payment in full, and only 20 percent of the physicians nationwide accept assignment in all cases. Thirty-five percent of the nation's physicians never accept assignment under any circumstances. The refusal by such a large number of physicians to accept Medicare reimbursement rates as payment in full has resulted in elderly patients being required to make large out-of-pocket payments for health care.

Congress requires hospitals, nursing homes, and home health agencies to accept Medicare reimbursement as payment in full. Farm Bureau supports the idea of requiring physicians to accept assignment in all cases as a precondition to treating Medicare patients. We recognize the argument that some doctors may choose not to treat Medicare patients. Due to the fact that the elderly now represent 35 percent of the average case load and due to ethical standards, we believe that most physicians will treat Medicare patients. We also recognize that patients not covered by Medicare will be paying higher costs for medical services as well as higher Medicare taxes.

Mr. Chairman, I want to finish this morning by assuring you that Farm Bureau does not feel we can rely solely on the Congress or the government to solve our health care problems. We have tried to develop programs and activities within Farm Bureau to help solve these problems.

The American Farm Bureau Federation has had a nine member rural health advisory committee in existence for the past three years. We also enlist the services of a seven-member professional advisory group. Twenty-five state Farm Bureaus will have advisory committees actively involved in programs by the end of 1984. These committees give direction to negotiations for health insurance contracts covering memberships and to programs and activities to increase member understanding of health care costs and ways to reduce them.

Volunteer member support is evidenced by the number of programs and activities in which the members participate at county and state levels. In the past two years, more than 250,000 individuals were tested for high blood pressure at Farm Bureau functions. Farm Bureau received national recognition for the efforts of this program. Farm Bureau has also participated in health fairs, exhibits, joint meetings with health care officials, seminars, conferences at state annual meetings and direction for emergency medical technician continuing education. Safety activities have also been redefined as preventive medicine with economic proof of the savings in claims. This includes training in farm accident prevention, extrication for EMT's, developing a nationwide training program for farm operations and families in first care programs, education in training in the use of farm chemicals, a national symposium on nutrition, and a national conference on health issues.

Mr. Chairman, we appreciate the opportunity testify this morning.

Senator **Jepsen**. Thank you, Mrs. White.
Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. **Goldbeck**. Thank you, sir. I am Willis Goldbeck, the president of the Washington Business Group on Health. As you heard some very clear specific examples from Ford and Chrysler, I will try to give you an overview of the business circumstances in the United States today and where we think some major corrective procedures are needed.

You have a chart there that suggests that the total expenditure by business is going to be $70-plus billion. It is important we recognize that that is only a portion, indeed not even half, of what business spends on medical care in America today. That's only what is reflected in group insurance premiums. That does not include workmen's compensation. That does not include disability. That does not include rehabilitation. That does not include self-paid programs. That does not include a lot of the self-funded programs in small businesses that have no reporting responsibilities to the Government. It does not include corporate medical departments, occupational safety and health programs, ad nauseum.

So, when you hear the giant numbers that are put on the table even now, they are in fact small compared to the total numbers with which the Congress must come to grips.

Waste and excess threatens not only the companies you hear from such as Chrysler and Ford, but threatens the medical industry itself because it will not be able to continue to be a healthy industry as it is being attacked from all sides with the necessity of change. The same waste and excess threatens quality and access to care as well.

I think Congress is going to have to recognize that we will deal with rationing in America. The question is, how well we will deal with it, not whether we will deal with it. In many cases, the private sector will be involved more onerously than anything the Government has yet suggested.

I just offer one example. The most successful heart transplant program in America, at Stanford, is in large part successful not just because of their surgeons' skills but because they have two very good rules; nobody over the age of 50 and nobody who has other kinds of complicating medical problems. That's a rational kind of rationing from the standpoint of that particular unit of care delivery. It also raises many issues for the Government to consider.

We need an effective new definition of what we consider to be a success. Efficiency rather than excess; self-reliance rather than subservience to experts, and prevention more than cure. Success must be measured by how little care we need and by the outcome of the care that we must receive.

We have paid too much attention to whether or not particular kinds of cost shifting were justified on the merits of the individual instance. Cost shifting is simply a matter of taxation without having to vote. The shift of costs by Government does not equate to savings. The Congress or the administration can suggest that they have saved the

Nation money, when in fact that will not be the case unless there's been the kind of systemic change that Mr. Califano and Mr. Shelton were talking about.

We have also been hearing in the last few weeks and months that business ought to just look out for itself. We've heard this from some Members of Congress. We've heard it from some members of the administration. Well, I want it to be clearly on the record that our organization and its members do not believe that business should only take care of itself as though it was isolated from the rest of the economic and medical care circumstances of this Nation. To do so would absolutely bankrupt most community medical practices and facilities. Many companies could do just that today and it's very pleasant to note that they chose not look out only for themselves.

Everybody is following the economic incentives placed in front of them. I think it is reasonable to expect that as we change the economic incentives people will continue to comply with the economic imperative. Doing so raises at least a couple of what we call myths that the Congress will have to grapple with. Individual companies have grappled with them as they changed their own plans. Benefit plans that now and in the future may restrict the choice of the providers to whom the individual employees and their families may go, is an issue very much in the forefront of medicare and medicaid considerations as well.

There is no such thing as freedom of choice that has any meaning absent real information upon which to make choice. Our public today, including you and I as individuals, has no ability to discern among providers on the basis of publicly available information, comparing price, quality, and service. In fact, we are often told that there is no real way to measure medical quality.

Well, if there's no way to measure medical quality, then nobody should have any complaints about who the giver is of the medical procedure. We believe very strongly that there must be systems to measure medical quality, as complex as that may be. We have to recognize that there are no real markets unless there is a free and open flow of market information so that the buyer is on a parity basis with the seller in the purchase and sale of medical care. In that sense we are not dealing with anything any different than any other product.

If we do not do something soon about the waste, then the ultimate availability of health care will be threatened. Your own State of Iowa has taken a lead by the passage of the data access bill. This movement was led by a group of employers in Iowa. If the rest of the States do not do something similar, we will be forced into the worst kind of rationing.

With the right kind of publicly available information, we can ration intelligently. We can discern who are the efficient, high quality providers and design the economic incentives to reward them for what they do well, leaving the others to either improve or fall by the wayside through other normal economic competition.

It's considerably preferable to have this kind of rationing than to having a congressional committee or a Government agency determining who on the basis of age or wealth ought to receive specific services.

The other question that is often raised is whether or not, because one begins to manage costs, quality must automatically be reduced. We see no evidence of that in any of the programs that are available now.

Companies that we've worked with around the country can exhibit savings of 20 to 40 percent if they will become aggressive about cost management. There is no reason why medicare or any other program couldn't do as well and therefore reverse the pressure of economic incentives.

The excess in medical testing documented in journals—the excess in length of stay, the amount of medical procedures that are done in inappropriate settings by inappropriate level of providers—all leave ample opportunity for us to make corrective measures and improve quality, not reduce it. Excess hospitalization is not a benefit. It is an unhealthy burden.

You asked in your letter about cost. I suspect we are heading toward 15 percent of GNP by around the year 2000. If you look at the trends in aging and the technology and other factors that are exogenous to the health care system, that is a highly likely direction, if not finite number. I would caution you that following the historical trends and the statistical norms is a very shaky business because they are predicated on all the waste in the system.

If we really want to exercise good surgery on the medical care system and its costs, we must develop cost management strategies that involve the public and private sector working in tandem and are predicated on four basic principles: Rewarding efficiency, investing in prevention, defining outcome standards, and guaranteeing access to information so consumers at both the individual and the aggregate level, corporations, unions, governments, and association, have the ability to discern among competing providers.

Now I would like to suggest to you that there are a variety of steps that can be taken by Congress to facilitate these changes, both in 1984 and subsequently from 1985 to 1995 or thereabouts. A number of those are identified in the testimony and I will not review them all, but merely point out one or two that are on your agenda right now.

The PRO, professional review organization, regulations are coming out stipulating that nobody is supposed to have access to physicians' specific information, obviously a device designed to protect not the consumer, not the Congress, not the Federal budget, and surely not Ford and Chrysler.

The Social HMO program, the first major experimental effort designed to provide cost efficient long-term care in America, the result of private investment with cooperation of HCFA, is being put on hold by OMB. You can correct these problems.

The list is lengthy. In the years to come, we can eliminate the problem of defensive medical practices, which is understandable given the current malpractice situation, by establishing either on a nationwide basis or a State-by-State basis—a medical malpractice arbitration system that will remove the issue from the tort system. This is working in at least two places infinitely better than the Nation as a whole, in Hawaii and Wisconsin.

Other actions include removal of State barriers to negotiating care arrangements which many companies are now exercising, and not including any extra percentage increases in DRG rates for technology which is supposed to be cost efficient to begin with. These would be simple steps that could be taken in the very near future and contribute to the total cost management.

Finally, Congress should begin a process—and it may very well be through Joe Califano's commission or some other structural methodology that seems appropriate—to consider the changes in medicare benefits that would be at least as dramatic as the changes last year in medicare financing. If one was to start today and design a program to serve the elderly, we would not end up with medicare. That was designed to serve the providers and help the elderly. If it's to serve the elderly, it ought to deal with chronic care and long-term care. It ought not to exclude the custodial benefits which are the greater part of the care given at hospitals yet are unreimbursable when given at home in cost efficient and humane settings. We already hear threats about removing or reducing the hospice program before it hardly has a chance to get started.

Mental health care is rarely reimbursed in those subacute facilities which are more cost effective and not at all worse from a quality standpoint, based on some 20 years of comparative studies.

We could bring about a long-term care IRA, we could start a prevention program for the elderly for whom there is absolutely no biological reason to fall apart at age 65.

I would hope as you look ahead you really look ahead, not just to 1984, not just to the next election, but to the future years. After all, we are still tinkering with the results of the decisions made in 1965. The decisions made in 1984 and 1985 will have a long, long life. They ought to recognize that the society which we will be serving will not be the family of today, will not be the classic nuclear family, and will not have a family doctor. We will be dealing with entire new types of medicine, entire types of new medical technology. The hospital will be the minority care giver, not the majority care giver.

All of these things suggest that those who emerge as real leaders in Congress will be those who are willing to take a more future-oriented perspective than is the norm.

In closing, your task requires seeking a balance between competition and regulation. Making market forces work is often a process of also making regulation work. You would not have full disclosure in Iowa, for example, were it not for a new law. Seeking balance between medicine and health. We are kidding ourselves if we continue the absurd imbalance that Joe Califano referred to with 96 percent of our medical dollars going to care after the fact and 4 percent going to prevent the probem. That is a problem we can correct today.

We must also seek the balance between public and private responsibility, not by fiat or by cross-shifting, but by a rational process of policy development.

Finally, we cannot avoid the difficult and often gut-wrenching but essential process of seeking balance between economics and ethics. When we talk about rationing, we're talking about the values of a society, not just the economics of the health industry. And just as businesses look at their bottom line with great scrutiny and increased care these days, we, too, must also recognize that the only way in America to make profits in the future is to have communities that are physically and emotionally healthy and economically viable. We need a total perspective of working together. Thank you very much.

[The prepared statement of Mr. Goldbeck follows:]

PREPARED STATEMENT OF WILLIS B. GOLDBECK

HEALTH CARE AND THE ECONOMY

You are to be commended for calling this hearing so that, together, we may ponder a true dilemma: the economic problems caused by the growth of our most economically successful industry. How ironic that, at the very time when our nation's economic problems and industrial decline are the focus of world attention, we find ourselves convened to devise strategies for slowing one of our few growth industries. By every standard of economic growth, the health care industry is a raging success. Unfortunately, that success has been based on a whole series of faulty economic principles, ignorance, and myths. Further, we must change our definition of success or else the failures of the past will preclude achievement of the wonderful future we all want to share.

As President of the Washington Business Group on Health, it is my responsibility to examine health in America from the perspective of the very large employer. Our members purchase care in amounts that stagger the imagination as their benefit plans annually provide for nearly 50,000,000 employees, retirees and dependents. However, it would be wrong to proceed under the assumption that, in the health care economic debate, there need be public vs private sector; management vs labor; provider vs consumer. Only by recognizing the mutuality of our long term interest will responsible programs be possible.

Progress is not served when the federal government claims savings that in fact are nothing more than shifts in cost to other payers or increases in poverty for which future Congresses will be held financially accountable.

Progress is not served if large employers act only to protect this year's bottom line and forget that their profits are ultimately dependent upon communities that are economically viable as a whole.

Progress is not served by tax policies which reward the largest companies for adding to rich benefits and also reward small employers for not providing benefits at all.

Progress is not served by unions that fight for the preservation of benefits, which we know today are poorly designed, economically wasteful and popular only because of the misconception that there is a positive relationship between the most expensive hospital care and high quality care.

Progress is not served when providers pretend they are the only ones with a right to comparative information or that somehow their industry should not be subject to the same requirements of both economic competition and government regulation as the rest of our industrial sectors.

Myths

Employers who have exhibited leadership in cost management have had to struggle with several myths that to this day impede the progress of many others in the public as well as private sectors.

Foremost among the myths is the concept of "freedom of choice." It is true that we have this legal freedom to go to any doctor or hospital we want. However, for most of us this freedom offers little more than psychic succor. When the buyer of a product or service is denied any quality or price information upon which to make a comparison among sellers the freedom to select is more rhetoric than value. This is true with any product and the medical industry is no exception. Ask yourselves, right here in Washington, if you have ready access to hospital infection rates, iatrogenic disease rates, morbidity or mortality rates per diagnosis or even price per procedure. Where do you get the physician specific information that would be comparable to what you would demand from the seller of any other product? Do you know which hospitals in the area do the volume of open heart surgery that results in the best outcomes; or which hospital has the most medically appropriate lengths of stay for normal births; or which do the least unnecessary lab tests . . . the list is endless.

The point here is not to suggest that quality is easily measured or understood, rather it is to state clearly that real freedom is dependent upon real knowledge; real markets are dependent upon open access to meaningful information.

For you as policy makers and we as purchasers the availability of quality standards and measures has another vital function: assessing the impact on health and access to care of our cost management strategies.

Predictably, the more government and private payers become demanding purchasers the more the providers are going to resist. Everyone has been responding logically to their economic incentives and there is no reason to expect this to change. Typically, those of us who advocate aggressive cost management are charged with not having an interest in quality. This is the second myth: to have costs controlled quality must be reduced. Not true. Cost management means getting people the care they need in the most appropriate setting, from the most appropriate provider based on an economic system that rewards the efficient. There is no positive correlation between the most expensive care and the best care. Extra hospitalization is not a benefit, it is a distinctly unhealthy risk. Lab tests done due to habit, ignorance, economic imperatives or defensive medicine are unforgivable. We need not spend billions on hospital expansion when we know other settings would be less costly and better for the patient. We need not accept the wide diversity in physician practice patterns when we have evidence of efficient practices with excellent medical results.

No, cost management is not the biggest threat to quality. Quite the reverse is true for if we do not adopt a conservative pattern of resource consumption we will rush into explicit rationing by age and/or wealth. Faced with these two choices, responsible cost management must be viewed as a protection of quality and access.

Cost Projections

Projecting costs is an exercise usually predicated upon the analysis of past consumption patterns. In the case of medicine, I believe this will prove to be a fruitless exercise.

Virtually none of the factors which have contributed to our current level of expenditures will be present five years from now. Actually, most are already gone or at least their altered state is recognizable. Ten examples:

1. the change from retrospective to prospective pricing of Medicare.

2. private purchasers -- employers and unions -- replacing an era characterized by the passive payment of insurance claims with the aggressive negotiation for medical services.

3. the public interest in fitness, stress control, reduced

smoking, self-care, and general health enhancement.

4. aging: without a supporting youth generation

5. technology: through the space program, genetic engineering, parts replacement and regeneration

6. replacement of the hospital as the primary focus of medical care

7. information that enables the public to shop for care based upon comparative quality, service and price measures.

8. economic incentives, from both the supply and demand sides, that foster competition

9. an increase in economic constraints from factors exogenous to health

10. greatly increased pressures to control and clean up environmental hazards.

All of these examples simply demonstrate the fragility of any projections. My best guess is that the pressures from aging, technology and the absence of major investment in prevention will combine to make costs continue to increase until we are spending nearly 15 percent of our GNP. We should reach this level before the year 2000.

Interestingly, this need not be a morbid prediction. Spending large amounts on human health is not the worst thing of which a country can be accused. The real issue will be whether or not we feel we are getting an increased return on our investment. Today, our system is marred by waste. Excess is driven by economic incentives and the absence of either progressive market forces or workable regulations. Increasingly, we see the staggering cost of care that is inappropriate in terms of location or provider, unnecessary, duplicative and even fraudulent. In this climate, there is a national desire to cut back, a desire reinforced by the overall deficit, unemployment and industrial realignment issues with which this Committee is so familiar. And, reductions are certainly achievable. Nearly any major private employer can reduce their outlays by 20-30 percent by adopting a strategy of reimbursement redesign, utilization controls and capacity constraints in which the efficient providers are rewarded. This is not a new concept. Walt McClure has been preaching this sermon for years just as John Knowles preached about prevention to overfed audiences of smokers impatient for the cocktail hour. The challenge is not to find new knowledge, rather it is to have the political will to do what we know can work.

Between 1985-1995 will be the difficult period. Even if we take effective actions, there will be a lag time before the excess is reduced, before physicians practice patterns change to comply with responsible national standards, before the public is educated to be more prudent both in their life style and in their consumption of medical resources, before there is an appropriate mix of providers and institutions competing openly on the basis of quality, service and price.

Action - 1984

Realistically, this is not going to be a year of fast action or high drama in federal health legislation or regulation. Nonetheless, the year need not be wasted. There are several steps the Congress can take immediately that address the basic principals of:

A. increasing market forces by identifying and rewarding efficient providers

B. improving our ability, as a nation, to assure access to the appropriate care for all in need

C. sustaining the excellence of our medical system while, for the first time, making a balanced investment in prevention.

In no special order, Congress should:

1. Require that all states within three years, have a full disclosure law at least as strong as the Iowa model.

2. Prevent the Professional Review Organization program regulation, being released for comment this week, from protecting the release of physician-specific price and quality information under the guise of confidentiality. No other supplier to the government is allowed to hide its costs, prices and measures of quality effectiveness and their exists no special reason to extend this unhealthy and economically unsound protection to physicians.

3. Support the start of the Social HMO long term care experiment now being held up by OMB despite years of investment by the private sector and the support of DHHS.

4. Clarify that the recent IRS memo on Section 125 flexible spending accounts not end the progressive development of creative benefit designs which encourage consumer multiple choice, self-responsibility and prudent purchasing.

5. Renew the Educational Assistance Program which included life style worksite wellness programs. These are the kinds of cost effective investment that the IRS, after years of analysis,

determined, in 1983, it was appropriate to support. Neither the analysis nor the effectiveness nor the need for prevention have changed . . . let's renew the support.

6. Pass an FTC reauthorization bill which does not provide any exemption for the professions. To do otherwise would be to make a mockery of the Congress' avowed concern for medical care costs or competitive markets.

7. Establish a new health planning program that meets the needs of the next ten years. Such a program needs to have considerable state and local control; a focus on the restructuring of the delivery system as it becomes less dependent upon the hospital; and a participatory process which rewards the improvement of health not just the denial of construction.

8. If the Congress gives serious consideration to a cap on the amount of insurance provided as an employee benefit which is tax deductible, then the life style and prevention programs provided by employers and unions or corporate medical departments should be exempt. To do so would send a clear signal that the government places a high value on the future health of our residents and recognizes that long term cost management must involve the prevention of illness whenever that capability exists. Taking this step would be no more

radical, and no less dramatic in its influence, than the original decision to use tax deductions as a means for encouraging the spread of medical insurance itself.

9. Eliminate all government subsidies for tobacco growing and production.

10. Provide the Prospective Payment Assessment Commission with a budget adequate to meet its mandate. That organization must have a quality, depth and duration commensurate with the scale of the investment it seeks to protect.

Action - 1985-1990

Starting next year, we enter the final four years in which it will be possible to act before Medicare self-destructs. It will be to all our advantage if Congress will view this as a block of time rather than four separate years. Components of a legislative strategy should include.

1. Increasingly strong incentives for the states to foster competition and efficient providers.

2. Establishment of medical liability (malpractice) arbitration systems in all the states and at the federal level for Medicare.

3. Removal of state barriers to negotiated care arrangements.

4. Chartering of a public-private technology assessment institute.

5. Conduct a review of all state medical practice acts that impede competition.

6. Incorporating capital into the DRGs.

7. Avoiding any percentage increase in DRG rates for new technology. Advances must be economically efficient over their life cycle. No other industry receives a future price increase guarantee for technology, and medicine should not be an exception.

8. While we do not need another commission to investigate why Medicare has problems, we do need to make the reform of Medicare benefits the focus of a national effort. It simply makes no sense, either economically or from a health perspective, to continue a program which pretends to meet the needs of the elderly while it blatantly ignores their most

pressing needs: chronic care, long term care and social services. We have made progress in changing the economic principles of Medicare but have not made the concomitant adjustments to the benefits so they suit user needs rather than provider demands. Medicare today, while better than nothing, is a cruel hoax for many of the elderly. A hoax we can no longer afford.

Corrective action must recognize that the elderly are not a single group. As the most creative gerontologists have noted, there are at least three categories: the young-old (55-65), the elderly (65-75), and the aged (75 and beyond). The categories are arbitrary. Some note that the over 84 group is the segment that, proportionately, consumes the most Medicare resources. No matter. The point is we must redesign the program to fit the population of the '90s and beyond or else we guarantee that we will remain mired in a morass of false expectations, financial waste and reduced access. In sum, it should be a simple choice.

8.a. Combine Medicare parts A and B

8.b. Combine Medicare and Medicaid

8.c. After holding harmless all those over 55, means test Medicare for those with an income over the same level as that used for Social Security taxation.

8.c.1. Move the eligibility age back to reflect the financial and health conditions prevalent in the 1990s, as opposed to those presumed present in the early 1960s. Set the age based on analysis of future needs not past norms nor Bismarkian allegiance to a biologically meaningless number.

8.d. Establish a health and medical care IRA with a designated kinship access provision for the payment of medical expenses after a selected age.

8.e. Develop a prevention package for Medicare that begins ten years before normal Medicare eligibility and is cost shared by participants, employers and the government.

8.f. The entire mental health component of Medicare needs to be redesigned to encourage sub-acute facilities, coping skills and direct reimbursement for non-physician providers who comply with utilization review standards.

9. Sponsor a national program to increase the use of living wills.

10. Do not renege on the new hospice program. In fact, that program should be increased to further encourage the at-home option and respite care for kinship support.

11. Greatly increase support for research to establish chemical safety standards.

2000 and Beyond

Your efforts to strike a balance between expenditures and access, laudable and necessary as they are, will fail unless the characteristics of our society, our technology and our place in the world are given due consideration. I appreciate how hard it is to adjust political thinking with its two, four and six year boundaries to long term needs. However, that is the dilemma from which leaders emerge.

The year 2000 is no further away than a new baby's junior year in high school, i.e., less than three terms in the U.S. Senate. By then the major global health issues of water, food distribution, nutrition, the environment and hazardous waste will be far more significant for the U.S. than they are today.

Our world will have expanded considerably beyond our earth with untold health consequences. Few if any domestic social issues will be as heavily impacted by our incursions into space as will human health. This hearing is being held on a day when U.S. and Soviet scientific teams are hard at work hundreds of miles above this planet. The foremost commercial and peaceful use of the space shuttle, and subsequently of space stations, is pharmaceutical development predicated upon otherwise unattainable chemical separations and interactions.

One of the reasons we have today's cost problems is that, in the past, we tried to treat medical care as though it was isolated from the rest of our social and economic needs. Rarely have we ever taken a dispassionate, comprehensive view of our medical needs. If we had done so, research into the prevention and cure of cardiovascular problems would receive approximately ten times the resources as those devoted to cancer, yet the reverse is true because the cancer lobby has been more effective than their heart disease counterparts. If we had done so, mental health, dealing as it does with humankind's most intricate and vital instrument, would not be the financially weakest element of medical care. If we had done so, we would not have based Medicare on an acute care hospital model, much less been surprised at the rapidly growing older population.

A strategy for the future cannot afford to ignore either these larger world issues or the lessons from our domestic past. Our family structure is no longer the nuclear stereotype; the classic family doctor is a rarity; everyone will have access to their medical records and massive banks of self-care data via telecommunication . . . at home; medical professionals will have instant access to the latest techniques, best research, total medical history regardless of where records may be located; diagnosis will be increasingly dependent on electronic implants that warn of pending problems as well as correctly pinpointing the cause of crises; compliance with drug regimens will not be an issue as time release capacity is extended to 12 months and beyond. These factors, combined with parts replacement, elimination or control of many emotional disorders and the as yet largely untapped potential of diet and psychological control of disease, represent a world that we will not avoid yet are ill prepared to enter. Unless the work we do to address medical care costs in 1984 at least considers the future we can guarantee only one result: more expensive problems that could have been avoided or ameliorated.

Impact On Industry

Throughout the nation, the cost of providing medical benefits has captured the attention of business leaders. Recognition grew in the 1970s that employers and unions must accept responsibility for benefit designs and lax management which contributed to excess medical utilization and uncontrolled cost increases. Between 1980 and today, major employers have initiated unprecedented efforts to correct their share of the problem and bring direct pressure on the other components of the medical care financing and delivery system. In these few years, more than 100 new purchaser groups have been formed at the regional, state and local levels; wellness programs are the most widely supported new employee benefit; increases in cost sharing have become common reversing a 30 year trend; financial incentives to modify utilization through second opinion, pre-certification, ambulatory surgery, utilization review, hospice care, home care and HMOs have become basic components of plan design; multiple choice plans, primary care gatekeepers and negotiated care plans with designated (preferred) providers are rapidly replacing traditional insurance policies; hospital trustees are learning to ask how their institutions can do better with less rather than how large a contribution is needed for unwarranted expansion; business is politically active across the country from Massachusetts to California where seemingly opposite approaches merely substantiate that Fortune 500 type companies may think nationally but they act locally.

All of this activity is completely understandable when one looks at the stakes involved. For many of our members, costs have escalated at rates ranging from 15 to more than 40 percent in each of the past five years despite no increases in benefits, fewer employees and more cost management. The medical benefit has become a major component of total compensation. No longer something to be given away and forgotten, the medical benefit is now seen as an asset to be jointly managed by employee and employer.

Not surprisingly, these problems have been most acute in the older, manufacturing, industries. For them, medical care cost inflation has simply exacerbated an already complex and dramatic period of decline. The ability to compete internationally has been hurt by excess medical expenditures. Equally important has been the impact of cost increases on firms that build everything from tractors to the space shuttle. In the past year, for the first time, I have heard management place the relative cost of medical care into the equation by which they will select future plant locations.

Small businesses find the cost of insurance so high that nearly half do not provide this benefit . . . a cost avoidance which shows up on government budgets and uncompensated care costs which are shifted to large employers!

For your purposes, these points are worth highlighting:

1. Solving the medical care cost problem will not save any troubled U.S. industry, but not solving the problem will inevitably add companies to the list of casualties.

2. Shifting costs from public to private payers does not reduce the nation's medical bill.

3. New government regulations should emphasize maximum state and local flexibility.

4. Those in government who now urge major companies to "look out for themselves," fail to recognize the havoc this would cause in countless local communities. In many towns, employers could hire their own specialists, build or buy their own facilities and leave the rest of the community to themselves. Happily, we see little evidence of this emerging. On the contrary, our Group and an increasing number of the local groups are starting projects to work with the rest of their community on indigent care, the "uninsurables," and the employment problem that will arise as the current hospital system shrinks. Business must protect its bottom line and needs no reminders from government to do so. But, that bottom line includes the economic and human health of our communities. We need a business community that is progressively agressive about cost management, not regressively protectionist.

I began by saying we needed a new definition of success. Employers have a critical role to play in gathering and disseminating the information which will build that new definition around efficiency rather than excess, around self-reliance rather than subservience to so-called experts, around prevention rather than cure, around rehabilitation rather than institutionalization, around health education rather than medical ignorance. Success must be measured by how little care we need and by the outcomes from that we receive. That would be a system we could all afford.

Conclusion: A Search for Balance

During the months ahead there will be many temptations to grab for fast solutions, to embrace the rhetoric of impassioned advocates, to leave political courage for the next generation. We would all be well advised to take a different course, to have a larger vision predicated upon a search for balance. Balance between competition and regulation, for we will never be a society of only one direction. Neither represents perfection, each benefits from the stimulous of the other. Wise regulations can make competition work just as surely as the opposite is also true.

Balanced investment between medicine and health, for we will not be able to afford our medical miracles unless we reduce demand by inculcating persons of all ages with the credo of health promotion.

Balance in the division of responsibility between the public and private sectors. Employers need to understand that they cannot avoid the costs of care and that all trends in global economics, demography and domestic politics are increasing the scope of corporate responsibility for social services. Government, on the other hand, does not improve the overall economy or even medical economics by shifting costs, increasing the number of persons without program eligibility or decreasing our already meager commitment to health care services research.

Balance between the exigencies of economic pressures and the ethics by which the true value of a society is measured. No longer is ethics the arcane province of academics and philosophers. Death with dignity, organ acquisition, right-to-life and the rationing of new technology are now the language of daily headlines and high school discussions.

The economic resources we now waste on medical care threaten not just the competitive viability of our members, nor only the budgets of countless state and local governments. Significantly, this waste threatens the destruction of the very industry it now supports. With that destruction would come an end to America's pre-eminent position of medical excellence; a drastic reduction in the employment of millions of minority and female workers; greatly increased rationing by wealth; and no chance for the investment in prevention that holds such promise for future generations.

We must work together to prevent this unwanted and unwarranted destruction. We can have a competitive system which rewards centers of efficient excellence and protects, through appropriate regulation, the right of access to needed care for all Americans.

Senator Jepsen. Thank you, Mr. Goldbeck.

Mr. Hacking.

STATEMENT OF JAMES HACKING, ASSISTANT LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY JACK CHRISTY, LEGISLATIVE REPRESENTATIVE

Mr. Hacking. Thank you, Mr. Chairman. On my left and accompanying me is Mr. Jack Christy, who is one of AARP's legislative representatives.

We are here representing the nearly 16 million member Association of Retired Persons. With the statement included in the record, I will try to keep my remarks to a minimum.

AARP is deeply concerned about what is happening in the health care sector of the economy. If the health care costs, especially hospital costs, continue to escalate at double digit rates as they have for so long, accessible and affordable health care services will cease to be available to millions of Americans—not just the poor and the elderly, but also many of the workers and their dependents.

The health care industry is one of the Nation's largest and fastest growing economic sectors. In 1982, medical health expenditures totaled $322.4 billion. That, as your chart indicates, was roughly 10.5 percent of the Nation's gross national product.

The rapid growth in health expenditures has occurred because inflation in the health care sector has significantly outpaced general inflation in the economy for quite some time. Hospital costs are the leading factor in the health care cost spiral.

As you can see from our first chart, since 1967, the CPI has increased by roughly 198 percent, whereas hospital room rates increased by 520 percent over the same period.

Hospital expenditures are not only rapidly increasing, they are also the largest component—now approximately 47 percent—of personal health care expenditures.

The tremendous growth in health care expenditures is expected to continue on into the future. By 1990, total health spending is expected to reach some $758 billion, more than double where it is today. The health care cost escalation trend has serious consequences for the Federal budget. In 1982, the Federal Government spent $93.2 billion on health. That was $9.5 billion more than the year before and $88 billion more than in 1965. Clearly the trend in Federal spending for health care is creating great upward pressure on the Federal budget deficits and crowding out other budget priorities.

The most important factor fueling the growth in the health industry has been the expansion of cost-based, third-party reimbursement through the third party payment system.

The third party payment system, including both public and private components, has become the primary mechanism for financing the high cost of hospital care. The party payments now account for about 90 percent of all hospital expenditures and almost two-thirds of the expenditures for physician services.

Cost-based third party payment procedures are inherently inflationary. Hospitals are generally paid either on the basis of costs or charges. Similarly, physicians are paid according to the charges they establish for the services they provide. Therefore, the more services physicians render, the more compensation they receive. Thus, providers are rewarded with more and more income for giving more and more care and for requiring more and more costly, technically sophisticated plant and equipment.

In addition, because third party reimbursement structure favors institutional care, physicians tend to utilize hospitals which are the most expensive component of medical care.

Last year Congress passed legislation changing the way medicare pays for hospital care. While medicare's move to prospective payment, or so-called diagnostic-related groupings system, is a step in the right direction, AARP does not believe it will be effective in controlling systemwide escalation in health care costs. Because the DRG system applies only to medicare, hospitals can and will shift unrecovered costs to private payers. Therefore, there will be no or very little net effect compared to the systemwide cost escalation.

Because medicare is patterned after the structure of the health care industry in general, rapid escalation in health care costs, particularly hospital costs, is driving up the costs of the medicare program. Over the last 5 years, medicare expenditures have increased at an average annual rate of about 18 percent.

As our chart 2 indicates, nearly three-quarters of medicare expenditures represent payments to hospitals. The extraordinary rate of increase in hospital costs is rapidly driving the hospital insurance fund toward insolvency. The fund trustees project that the reserves will be exhausted by 1991. By 1995, the fund is projected to accumulate a $162.5 billion deficit.

Expenditures are also rapidly rising in the supplementary medical insurance or medicare part B program. Expenditures for part B were up to $18 billion in 1983. Three-quarters of that amount came from general revenues. The Congressional Budget Office projects that the share of this Government's general revenues necessary to finance the part B program which pays physicians will increase from 3.1 percent in 1982 to 5.7 percent of general revenues by 1988.

Congress and the administration have acted to reduce medicare expenditures over the past few years primarily through the introduction of higher premiums, deductibles and coinsurance. But these efforts merely shift costs to the elderly and disabled program beneficiaries and these efforts do not really address the underlying cost escalation problem. Financial remedies that are specific to medicare will not and cannot solve medicare's problems over the long run, nor contribute to a less cost escalating health care delivery system.

The most important step in moderating the rate of growth in medicare and total health care expenditures is to control the rate of growth in hospital costs. The only other options are to shift more costs to beneficiaries and over time deny more people access to these services, or raise taxes. AARP rejects these two options.

Medicare today provides about 45 percent of the health care expenditures of the elderly. On a per capita basis, the elderly are expected to spend $1,550 out of pocket this year and that would equal 15 percent of their per capita income which would roughly be $10,600. That 15 percent is the same percentage that the elderly paid for health care before medicare was implemented. By the year 2000, assuming no further cutbacks in medicare are enacted, the elderly will have to allocate nearly 20 percent of their per capita income to meet health care costs.

To deal with the cost escalation problem, AARP recommends that the rate of increase in hospital expenditures be limited to a fixed percentage that is reasonably in line with the general inflation rate. The limit once established should apply to all third party payments to hospitals. Some six statements have had some measure of success in limiting hospital cost escalation by utilizing mandatory prospective budgeting or rate review programs. It should be clear from our last chart.

In 1982, these mandatory review States limited increases in hospital costs to 10.8 percent, while in all other unregulated States hospital costs increased 16.3 percent.

Now given this experience, AARP supports the enactment of Federal legislation which would encourage or force the State to establish mandatory hospital rate review commissions to assure that increases in payments to hospitals do not exceed the national limit.

As for physicians, AARP favors a prospective pricing approach to physician payments. We support timely enactment of this concept with actual implementation occurring after adequate consideration of the appropriate prospective payment methodology.

In addition to controlling hospital and physician expenditures, AARP believes that limits must be established to control excessive growth of medical facilities and technology and health professionals.

Over the long run, AARP believes that regulation should gradually give way to the development of more market-oriented health care delivery systems. Competing forms of care delivery such as health maintenance and preferred provider organizations, small clinics, and ambulatory health care facilities of all kinds should be encouraged to the extent possible. Again, I must emphasize, in the short term, that across-the-board approach that limits the rate of increase in both hospital and physician expenditures for all third-party payers is required to slow the rate of growth in hospital costs and ensure a more stable, affordable health care delivery system.

That concludes my remarks. Mr. Chairman. Thank you.

[The prepared statement of Mr. Hacking follows:]

PREPARED STATEMENT OF JAMES HACKING

Thank you, Mr. Chairman, for the opportunity to share with this Committee the American Association of Retired Persons' (AARP) deep concern about what is happening in the health care sector of the economy. The persistence of double-digit cost-escalation in the health care marketplace has placed an increasing burden on health care consumers, both young and old alike. The Medicare program is in jeopardy as well as comprehensive coverage under private insurance plans. Because health care cost escalation is not a new phenomenon, some have become anesthetized to the short and long range consequences of this trend. AARP has not; we recognize that if health care costs, especially hospital costs, continue to escalate as they have, accessible and affordable health care services will cease to be available to millions of Americans--not just the poor, but the elderly and millions of workers and their dependents, too.

AARP commends this Committee's leadership in exploring this difficult and politically sensitive issue. The Association's testimony today will consider four principal issue areas:

1. the growing problem in the health care marketplace;
2. the impact of cost escalation on Medicare and private health insurance;
3. the high out-of-pocket costs the elderly must pay for health care; and
4. AARP's policy proposals to fashion a more rational, less cost escalating health care system over the short and long term.

GROWTH IN THE HEALTH CARE SECTOR

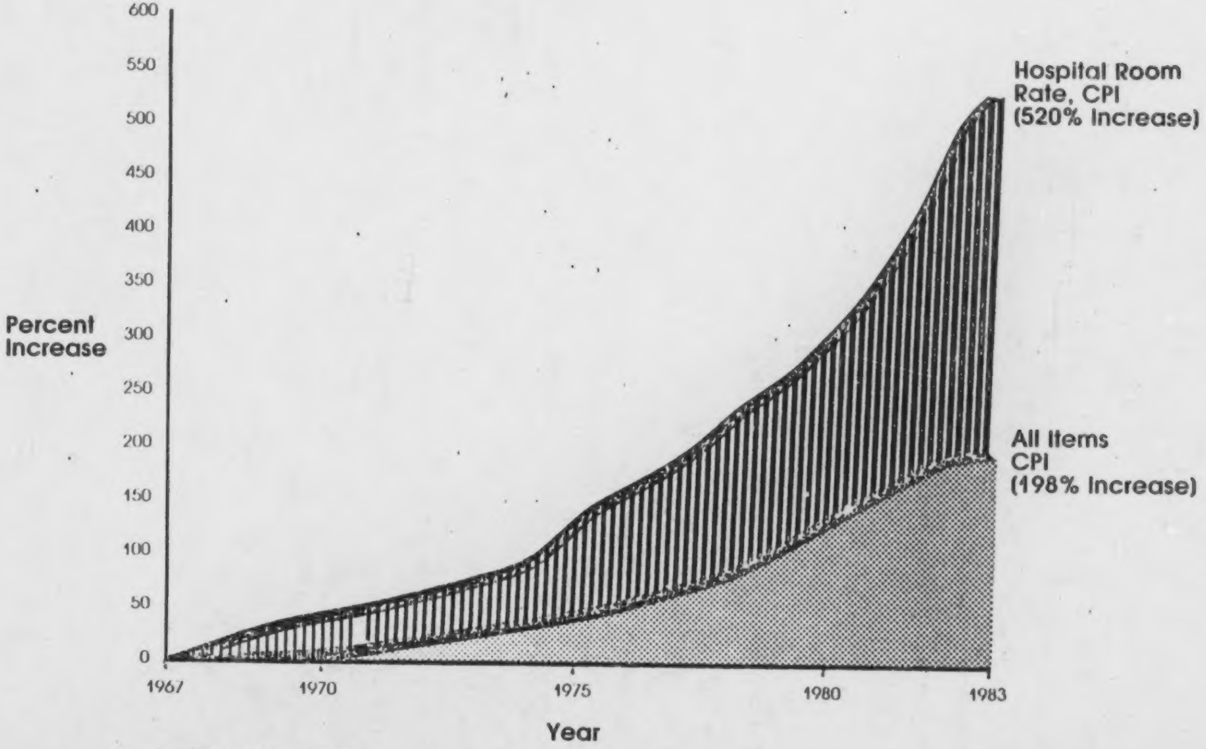
The health care industry is one of the nation's largest and fastest growing economic sectors. Between 1967 and 1982, total national health expenditures increased sevenfold from $51.3 billion to $322.4 billion--that is a spending rate of over $1 billion per day. Health care spending has also been taking a larger share of the nation's total resources--rising from 6.4% of GNP in 1967 to 10.5% in 1982.

This rapid growth in health expenditures has occurred because inflation in the health care sector has significantly outpaced general inflation in the economy for quite some time. Hospital costs are the leading factor in the health care cost spiral. Since 1967, the general (all items) CPI has increased by 198%, whereas hospital room rates have increased by 520 percent, about two and one-half times greater than the increase in the general CPI (Chart 1). Although not quite as dramatic as the rate of hospital cost increases, physicians' fees have also significantly outpaced the increase in the general CPI. Since 1967, the physician fee CPI has increased by 252%.

Hospital expenditures are not only rapidly increasing, they are also the largest component of personal health care expenditures. Hospital expenditures have grown from $13.9 billion in 1965, equalling 39% of all personal health care expenditures that year to $135.5

CHART 1

SOARING HOSPITAL COSTS



Source: U.S. Bureau of Labor Statistics

billion in 1983, equalling 47% of personal health care expenditures.

Despite the sharp decline in inflation since January 1983, health care costs have continued to escalate at unacceptable rates. In 1983, general prices increased by only 3.2% whereas medical prices increased by 8.7% or more than twice as fast. Hospital room rates continued to be the leading factor in health care inflation. In 1983, hospital room rates rose 11.3%, a rate of increase more than three times greater than the increase in the general CPI.

The tremendous growth in health care expenditures is expected to continue in the future. Unless the current health care financing and delivery system is changed, by 1990, total health spending will reach $757.9 billion, more than double what it is today. Even with the enactment of the Medicare prospective payment system, hospital outlays under Medicare Part A will increase by 11.5% a year between 1985 and 1995. Of this projected increase, 7% is attributed to the increasing price of hospital care, 2% is attributed to increased admissions, 1.5% is attributed to changes in medical practice, and only 1% is attributed to the increase in the size of the eligible population.

The health care inflationary trend has serious consequences for the federal budget. In 1982, the federal government spent $93.2 billion on health, $9.5 billion more than the year before, and $87.7 billion more than in 1965. Federal health expenditures (tied as they are to private sector prices for health care services), if left unchecked, will continue to escalate to over $231.6 billion in 1990, equalling more than 30% of all expenditures for health care in that year. Clearly, the trend in federal spending for health care is creating upward pressure on federal budget deficits and crowding out other budgetary priorities.

FACTORS CAUSING RAPID GROWTH IN THE HEALTH CARE SECTOR

The most important factor fueling the growth in the health industry has been the expansion of cost-based, third-party reimbursement. The third party payment system had its inception during the Depression. At that time insurance plans were developed to reimburse for hospital charges. Plans were designed in this manner to enable hospitals to remain financially solvent during times when increasing unemplyment and decreasing wages made it difficult for workers to pay for unexpected hospital stays. The provision of health insurance protection, patterned after these early hospital insurance plans, grew during the 1940s and 1950s in response to several factors, including:

1. the exclusion of health insurance from World War II wage controls;
2. the inclusion of health insurance benefits as compensation in the collective bargaining process; and
3. the favorable tax treatment of employer-paid health insurance premiums.

Consequently, third-party reimbursement became the widespread mechanism to finance the high cost of hospital care.

Even before Medicare, hospital costs had demonstrated a pronounced tendency to rise at rates higher than prices in general. Between 1950 and 1965, the CPI showed an increase in the costs of semi-private hospital rooms of 2 1/2 times, whereas the general level of prices rose over the same period only by one-third. The adoption of third-party payment procedures by the government through Medicare and Medicaid only made matters worse.

Third-party payments now account for over two-thirds of all personal health care expenditures, about 90% of all hospital expenditures, and almost two-thirds of the expenditures for physician services.

Cost-based, third-party payment procedures are inherently inflationary. Hospitals are generally paid either on the basis of costs (what the hospital spends to provide goods and services) or charges (the amount a hospital bills for the goods and services it provides). As a result, there is no incentive to restrain spending since more spending means greater revenues. Similarly, physicians are paid according to the charges they establish for provided services. Therefore, the more services physicians render, the more compensation they receive. Moreover, unlike purchasing other goods and services, physicians, rather than consumers, determine both the quantity and prices of services rendered, including the necessity of a hospital admission and where it will take place. The consumer plays virtually no role in this process. Instead, providers are rewarded with more and more income for giving more and more care, and for acquiring more and more costly, technically sophisticated plant and equipment, whether or not such activities are necessary or beneficial. In addition, because reimbursement favors institutional care, physicians overutilize hospitals, the most expensive component of medical care.

In 1983, Congress passed legislation to change the way Medicare pays for hospital care in an attempt to alter inflationary incentives inherent in traditional third-party payment procedures. Under the newly created DRG payment system, Medicare will pay hospitals a pre-determined price for each hospital stay. While Medicare's move to prospective payment is a step in the right direction, AARP seriously questions its effectiveness in controlling system-wide escalation in health care costs. Because the DRG system applies only to Medicare, hospitals can charge higher rates to private payors in order to regain lost Medicare revenues. Total costs remain the same; the burden of paying these costs is just shifted among payors. In addition, the yearly rate of increase in DRG payments remains tied to a system-wide measure of hospital inflation. To the extent that system-wide costs are not constrained, the system-wide measure of hospital inflation remains inflated, driving up Medicare costs beyond what they would be if there were system-wide constraints on hospital costs. Finally, the DRG payment system does not address other factors which contribute significantly to hospital costs such as increased utilization.

Government has encouraged the growth of the third-party reimbursement through its tax laws. Both employer and employee health insurance premium payments are excluded from taxable income. Revenue lost to the U.S. Treasury as a result of this exclusion totaled approximately $16.6 billion in FY 1982. In addition to this health insurance subsidy, Blue Cross/Blue Shield plans have been tax-exempt in most states.

Government subsidies to increase the supply of medical services have also influenced the rate of growth in health spending. Hospital expansion has been stimulated by the Hill-Burton program, the tax exemption of hospital construction bonds, and the greatly liberalized business depreciation schedules contained in the 1981 Economic Recovery Tax Act. Construction expenditures for medical facilitiies which totaled $7.5 billion in 1981 are expected to reach $11.5 billion in 1985 and $17 billion in 1990. The supply of health professionals has been stimulated by billions of dollars in federal spending for health education and training.

Advances in medical technology have also created pressures which increase costs. New technology and high-cost therapies often require captial acquisitions which are in and of themselves costly. New technologies also require the addition of highly specialized personnel. In addition, hospitals in a single community often duplicate these high specialized and expensive services, leading to underutilization and inefficiency.

THE IMPACT OF RISING HEALTH CARE COSTS ON MEDICARE ARE PRIVATE HEALTH INSURANCE

The most important health care program serving the elderly is Medicare. There is no doubt that the enactment of Medicare in 1965 has greatly increased the access of the elderly to health care. However, continued high rates of health care inflation threaten to defeat the access originally gained.

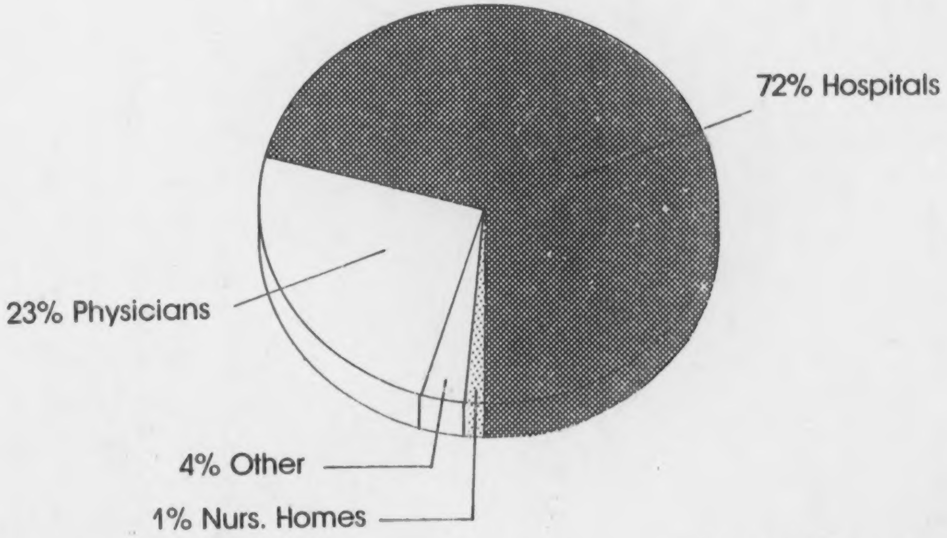
Because Medicare is patterned after the structure of the health care industry in general, rapid escalation in health care costs, particularly hospital costs, is driving up the costs of Medicare. Over the last five years, Medicare expenditures have increased at an average rate of 18% per year. In FY 1983, Medicare expenditures totaled $56.9 billion, up 12.7% since FY 1982.

With nearly three quarters of Medicare expenditures spent on hospital care (Chart 2), rising hospital costs, combined with other adverse economic circumstances, are taking their toll on the Hospital Insurance (HI) Trust Fund (Part A), the main social security trust fund financing Medicare. The HI Fund's Trustees project that the Fund's reserves will be exhausted by 1991 and that the fund will never regain solvency over the entire 25 year projection period. By 1995, the (HI) Fund is projected to accumulate a $162.5 billion deficit. (This assumes that the rate of increase in DRG payments will remain at

CHART 2

How the Medicare Dollar Is Spent

1982 Total Medicare Expenditures:
$50.5 Billion



Source: Health Care Financing Administration hospital market basket plus one percentage point after October 1, 1985 even though that amount of increase is only mandated by law through 1985. After October 1, 1985, the Secretary of Health and Human Services has the discretion to determine the yearly rate of increase in DRG payments.)

Although the crux of the Medicare shortfall is in the HI fund, expenditures are also rapidly rising in the Supplementary Medical Insurance (SMI) Fund (Part B). Since 1967, fiscal year expenditures for Part B have increased from less than $1 billion to more than $18 billion in 1983. Because three-fourths of Part B is financed by general revenues, it is not in danger of bankruptcy. However, the projected growth of SMI is significantly higher than the growth in general revenues. The Congressional Budget Office projects that general revenue contributions to SMI must increase about 17% per year to finance growth in the Part B program. To meet Part B's anticipated demand, CBO projects that the share of general revenues necessary to finance the SMI Trust Fund will increase from 3.1% to 5.7% between 1982 and 1988.

Rising health costs are a serious problem, not just for government health programs like Medicare, but also for the private sector. Since 1965, there has been significant growth in private expenditures for health insurance coverage. Growth in premium income of all private insuring organizations has been particularly rapid since 1975. In 1975, premiums paid for private health insurance totalled $36.9 billion. By 1981, this amount had grown to $84.8 billion, a 130% increase in just six years. Most of these expenditures represent employer-paid health insurance premiums. The rising costs of this coverage can lower wages for workers, and/or cause higher prices for goods and services. For example, Chrysler recently estimated that its $373 million annual health insurance bill for its workers is adding $600 to the price of every car it manufactures.

Anxious to reduce the rate of increase in spending for Medicare, Congress and the Administration have drastically cut Medicare expenditures over the past three fiscal years, cutting $26 billion through FY 1986. This year Congress and the Administration are again seeking between $4 and $9 billion in additional Medicare cuts. This incremental dismantling of Medicare through the introduction of higher premiums, deductibles and similar measures that merely shift costs to beneficiaries does not address the underlying problems in the program and therefore has little impact on the escalation of costs in Medicare or in the health care sector. It should be clearly understood that extraordinary inflation in the health care delivery system is the root cause of Medicare financial difficulties, not vice versa. Financial remedies that are specific to Medicare will not and cannot solve Medicare's problems over the long run, nor contribute to a healthier delivery system in general.

The most important step in moderating Medicare and total health expenditures is to control the rate of growth in hospital costs. Without stable hospital costs:

*National health expenditures will continue to escalate beyond reason;

*the HI Trust Fund will continue to deteriorate;

*employers will be required to pay higher health insurance premiums which will, in time, be passed backward onto workers in the form of lower wage gains or passed forward to consumers in the form of higher prices for goods and services; and

*all health care consumers, including the elderly, will pay higher out-of-pocket costs for health care.

THE ELDERLY ARE THE MOST COST CONSCIOUS HEALTH CARE CONSUMERS IN THIS COUNTRY

Most of the current proposals to reduce spending in Medicare are based on the notion that the elderly are not health cost conscious--that they are somehow insulated by Medicare from the "true" cost of health care. Because of this insulation, so the theory goes, the elderly misuse or overuse the system and thereby increase Medicare costs. AARP rejects this theory.

The elderly are the most cost conscious health care consumers in this country. They have to be. Medicare's contribution, as a percentage of the total health care expenditures of the elderly, only equals about 45%. The sad reality is: the higher the cost of Medicare, the less beneficiaries are getting from it.

Out-of-pocket payments borne by aged Medicare beneficiaries have outpaced the growth in elderly incomes. As a result, the elderly have been spending an increasing share of their mean per capita income in order to meet their health needs. Persons aged 65 and over paid roughly $700 out-of-pocket per capita for medical expenses in 1977. By 1984, according to conservative estimates, this amount is expected to increase by over 120% to $1550 per capita, equalling 15% of the annual mean per capita income of the aged ($10,615), the same percentage as the elderly paid for health care before Medicare was fully implemented. This deterioration in Medicare's protection is expected to continue. By the year 2000, assuming no further cutbacks in Medicare are enacted, almost 20% of elderly per capita income is projected to be consumed by health care expenditures (Chart 3).

BENEFICIARY OUT-OF-POCKET COSTS

Personal liability for the cost of health care provided to the elderly derives from a number of sources, all of which have been subject to significant increases over the past several years. The elderly pay directly for the following:

1. Deductibles under Parts A and B:

   The Part A deductible has increased from $104.00 in 1976 to $356.00 in 1984, an increase of 242% over the past eight years. The annual Part B deductible has increased from $60.00 in 1980 to $75.00 in 1983, an increase of 25%.

2. Coinsurance (Part B):

   Actual per capita coinsurance charges borne personally by

CHART 3

ANNUAL HEALTH CARE PAYMENTS MADE BY THE AGED

	Per Aged Person	Payments as a Percent of Income
1966 (Pre-Medicare)	$300	15%
1977	$698	12%
1981	$1198	14%
1984	$1550	15%
1989	$2208	16%
1993	$2892	17%
2000	$4637	19%

Source: Health Care Financing Administration, American Association of Retired Persons

2. Coinsurance (Part B):

   Actual per capita coinsurance charges borne personally by the elderly increased by 345% between 1972 and 1982.

3. Cost-sharing (Parts A and B):

   In 1981, out-of-pockets payments for deductible and coinsurance liability associated with both parts of Medicare totalled $5.6 billion, a 166% increase in such out-of-pocket payments since 1976.

4. Charge reductions on unassigned claims (i.e., the difference between the Medicare "allowed" charge and the actual charge by the physician for which the beneficiary is personally liable):

   Between 1977 and 1982, the total dollar amount of "charge reductions" passed on to elderly Medicare beneficiaries jumped from ~~[illegible]~~ $674 million to $2 billion, an increase of 198% over a five-year period. Approximately 46 percent of all Part B claims submitted to Medicare for reimbursement at this time are "unassigned," compared to an over-50% non assignment rate in 1977. Nevertheless, beneficiary liability for "unassigned" claims has increased dramatically over the past five years even though the number of claims paid on assignment has increased during the same period.

5. Non-covered services:

   Aged Medicare beneficiaries are personally liable for a significant number of critical non-covered services and products--including dental services, dentures, prescription drugs, eye glasses, hearing aids, etc.--for which they paid about $7 billion out-of-pocket in 1981, a 79% increase in their out-of-pocket liability for such products and services since 1977.

6. Coinsurance for Skilled nursing home care and charges for all ICF care:

Approximately half of all nursing home expenditures made on on behalf of the aged in 1981 were financed directly by out-of-pocket payments. As HCFA researchers have noted: "Even if other sources comprised half of the total payments, the average out-of-pocket expenditure for private-paying patients would still be over $100 per week."

7. SMI (Part B) premiums:

Out-of-pocket premium payments by the elderly for Medicare Part B coverage totalled $86.40 annually in 1977 as compared with a current annual figure of $175.20, a 103% increase in SMI premium payments by the elderly over the past seven years.

8. Private Health Insurance Premiums:

Approximately two-thirds of aged Medicare beneficiaries are sufficiently concerned about the gaps in Medicare coverage to purchase private health insurance policies designed to supplement medical expenses. Currently, low option private insurance plans cost aged Medicare beneficiaries approximately $230 per year, while high option plans can exceed $800 per year. These figures compare with an annual private insurance premium rate of $90 just five years ago. Finally, there is evidence to suggest that fewer and fewer of the elderly are financially able to retain such supplemental policies once they are purchased. Blue Cross/Blue Shield of Florida has recently pointed out that the "persistency rate" (i.e., the percentage of those aged beneficiaries who had coverage at the beginning of the year and continue to have coverage at the end of the year) has dropped from 93.3% in 1978 to 86.9% in 1982.

A NATIONAL COST CONTAINMENT STRATEGY

AARP advocates a system-wide approach to restrain the rate of increase in total health care spending. Cost containment proposals limited solely to Medicare (e.g., benefit reductions or changes in Medicare's reimbursement method, such as the newly enacted DRG payment system) encourage providers to shift costs to non-Medicare, private pay patients and therefore do little to reduce the overall rate of increase in hospital and health care costs. Such "solutions" accept the rapid increases in hospital and health care costs as a given and merely shift the cost burden among payors. Channeling ever more resources into a cost-inflated system, either by requiring Medicare beneficiaries to pay more or by adding more revenue raised through taxes, will not solve the problem of rapidly rising health care costs.

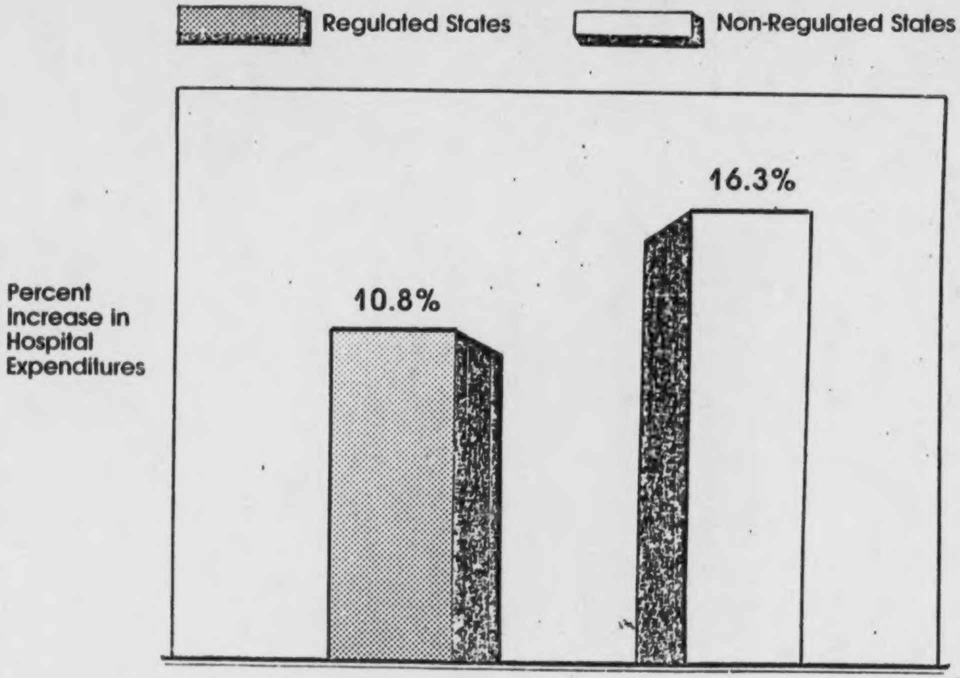
In the short term, AARP recommends that the rate of increase in hospital expenditures be limited to a fixed percentage that is reasonably in line with the general inflation rate. The limit once established should apply to all third party payments to hospitals. Six states (Massachusetts, Connecticut, New York, New Jersey, Maryland and Washington) have had some measure of success in limiting hospital cost escalation by utilizing mandatory prospective budgeting and/or rate review programs. As a result, increases in hospital costs in these six states have consistently averaged three to four percentage points less each year than in other states. In 1982, the mandatory review states limited increases in hospital costs to 10.8%, while all other states experienced hospital cost increases of 16.3% (Chart 4).

The experience in these six states demonstrates that hospital costs can be significantly restrained by regulatory action. The Association supports the enactment of federal legislation that would encourage or force the states to establish mandatory hospital rate review commissions to assure that increases in payments to hospitals do not exceed the national limit and also to control the growth and expansion of hospital facilities.

CHART 4

HOSPITAL EXPENDITURES UNDER MANDATORY RATE REVIEW SYSTEMS.

(1982 — 1983)



Source American Hospital Association

As for physicians, they have steadily increased their fees at rates in excess of the general rate of inflation for years, thus demonstrating an ability to maintain targeted income levels. Physicians, like hospitals, must begin to share more of the financial risk created by modern, high technology medicine. Thus, policy makers must seriously consider a prospective pricing approach to physician payments. AARP is not committed at this time to any particular method of establishing a prospective payment system for physician. We support timely enactment of the concept with actual implementation occuring after adequate consideration of the appropriate prospective payment methodology.

In addition to controlling hospital and physician expenditures, AARP believes that limits must be established to control excessive growth of medical facilities and health professionals. To help remove the economic incentives which have caused explosive growth in the supply of medical services, the Association recommends the following steps:

1. limit tax breaks that promote the excessive expansion of conventional medical facilities, particularly hospitals, such as over-generous depreciation deductions when hospitals/nursing homes are sold;
2. change tax laws to cause employers and private third-party payors to resist health provider cost escalation;
3. make health/medical insurance corporations subject to the antitrust laws by repealing any state or federal antitrust exemptions; and

4. subsidize the training of only those health professionals who agree to work in medically underserved areas, and provide incentive grants to health profession schools to encourage training and curriculum development in geriatrics.

Over the long run, AARP believes that regulation should gradually give way to the development of more market-oriented health care delivery systems. Health care delivery should be restructured to expand the supply of needed services that represent less costly alternatives to hospitals and nursing homes. Competing forms of care delivery such as health maintenance and preferred provider organization (HMOs and PPOs), small clinics, and ambulatory health care facilities of all kinds should be encouraged to the extent possible. Greater use should also be made of paramedical personnel (for example, geriatric nurse practitioners and physician assistants) especially in underserved rural and inner-city areas, and in such neglected institutional settings as nursing homes.

CONCLUSION

Health care cost containment is the most important domestic policy issue facing this nation. An across-the-board approach that limits the rate of increase in both hospital and physician expenditures for all third-party payors is required to slow costs and ensure a stable, affordable health care delivery system.

Senator **Jepsen**. Thank you. I thank all three of you for very excellent testimony and I would like to start off by asking a common question and have all three of you respond.

How do you feel about the proposal that was made here earlier this morning during Mr. Califano's testimony with regard to the formation of a National Commission on Health Policy?

Mr. **Hacking**. Mr. Chairman, AARP does not favor the idea of a commission, given our experience with the Social Security Commission. While I know that the package that the Social Security Commission assembled and delivered to Congress last year was hailed as a bipartisan compromise, our organization did not feel then nor do we feel now that what the Commission presented to the Congress and what the Congress enacted represented the best possible solution to the problems in the Social Security cash benefit area.

What was worse was that much of that package that was put together by the Commission was fashioned by a small group of Commission members acting in private and out of the public view without any access given to outside groups that had an interest, such as our own organization.

However, we felt that once the package was assembled and then was introduced into the legislative process here, there would at least be an opportunity for us as an organization to try to influence the package, get some significant changes made in order to improve it.

What we were hoping was that, on balance, we would be able to say that we could support it. What we found instead was that in the legislative process on Capitol Hill there was no opportunity to make any changes whatsoever in that package. No changes were going to be allowed and we were told that time and again and we went from office to office on the House side and the Senate side.

So from our organization's point of view, the Congress abdicated its responsibility to shape public policy and delegated that responsibility to a small group of people, some of whom are not even elected members of this body, and that we do not think the way public policy should be shaped.

We would hope that in dealing with the medicare problem and the more general problem of cost escalation, that the Congress would face up to the problem itself and handle the issue. After all, much of the problem has to do with the way the Government has structured the incentives in the health care marketplace through the tax laws and through direct and indirect subsidies to promote the growth and expansion of third-party payment system and promote the expansion of the supply of hospital facilities and medical personnel.

Senator **Jepsen**. Mr. Goldbeck.

Mr. **Goldbeck**. I think there's good reason to be concerned about whether or not a commission would produce a viable solution and if it was looked to from the standpoint of go away for a year and come back with the answer, I think that would be a mistake both in practical and political terms as well.

The rate of change in health care systems today suggests that there's more going on than can probably be grappled with within a year and also suggests that there isn't a simplistic list of sort of policy oriented answers that somebody is going to come up with to resolve all our health care problems in this country.

On the other hand, providing a national forum for an ongoing focus on health policy issues could be a very beneficial step, as long as we weren't too overly anticipating the finality of the outcome. And in that sense, we could certainly support the creation of such an endeavor.

I think that what he was referring to in terms of a commission to help develop a national health policy is an interesting set of terminology because, of course, health policy is not a law nor does a policy equate necessarily to legislative response. Witness the fact that we have one social service oriented national policy in America, which is in the housing area, where we have had since 1949 and then reiterated—and I'm sorry to tell you I can't remember—in either 1968 or 1969, a national housing policy that said that every American is entitled to housing in the following condition and it specifies it right down to toilets. It is a brief, yet rather detailed specification of what our housing policy is.

Yet only 26 percent of the people in the United States who are eligible for public housing are receiving public housing. The fact that there was a policy had virtually no impact on the subsequent legislation or private sector endeavors. So the mere creation of a policy doesn't produce a solution, but the exercise, I would posit to you, could be very valuable.

Senator JEPSEN. Mrs. White.

Mrs. WHITE. As you know, I speak for a conservative organization and when I speak this morning to give you that particular answer it will be more personal. I think all of us understand that commissions and studies can be quite expensive and again speaking from the grassroots organization, we do not feel that there's any better place to get the answer, to provide the study, to get the information or whatever is needed, than through and from our Congressmen and Senators who we elect and send to Washington. We feel that they are more concerned about the individuals, all of their constituents, regardless of their age and regardless of their physical and financial conditions, and we would be prone to continue to lean in that direction.

Again, as I say, not only are we conservative, but we are willing to cooperate and compromise in whatever is best for the people. And we recognize that there's no bigger issue right now facing the American public than that of the health problems that we see in the future and in the immediate future, as these gentlemen have stated and whose who preceded us, so we would do whatever we could to support any cause that would help to eliminate any of these problems and work toward a more positive health program. Thank you.

Senator JEPSEN. Thank you. There's no question about where any one of the three of you stand on that issue. I appreciate that.

Mr. Hacking, we heard testimony earlier which indicated that in at least one country health care is being rationed with respect to the elderly. Great Britain certainly denies certain procedures simply because they have gotten older. A bit closer to home, we've heard statements to the effect that the elderly have a responsibility for certain types of medical care. Frankly, I find this thinking disturbing and I wonder if you could tell us what, in terms of your association, you think about this development.

Mr. HACKING. Well, Mr. Chairman, care in this country today is already being rationed and I guess our organization is very much afraid that as the medicaid prices build and the Congress proceeds to deal with it, Congress may end up dealing with it by making very large shifts of costs onto medicaid beneficiaries, shifts so large that a very large increasing share of the elderly population will simply be precluded from entering hospitals and other medical facilities.

Therefore, it will be the poor and the relatively low income who over time, if our system continues as is, who will be precluded from access to care. So in that sense the rationing which has already begun will just continue and we will end up at some point in the future—in the not too distant future—with a highly technically sophisticated medical system that is able to provide care only for the well-to-do or those who have very expensive insurance, and that is not going to be the elderly population generally.

Senator JEPSEN. Well, you're advocating greater regulation in the medical area.

Mr. HACKING. In the short term.

Senator JEPSEN. Well, it seems there are some who believe that the regulation of Great Britain has had has contributed to some of the problems in the rationing of health care. If you remove any incentive on the part of the providers, do you discourage people from entering the field and you also discourage improvements in technology, and wouldn't it be better, as some of the witnesses suggested, to rely more on the market to control the costs rather than regulations so we don't lose the drive for research and improvements in the area?

Mr. HACKING. As I said in my statement, over the long term, the association does support a move away from regulation and toward these kinds of market-oriented approaches for delivering care. We think that the health maintenance organizations have a great deal of promise, as do preferred provider organizations.

The problem is that the cost escalation problem is at hand now. Medicare's impending insolvency is not too far down the road. We have to do something that is going to be effective now to dampen the rate of escalation of hospital costs and the only thing that we can reach for in the short term is strict across-the-board regulatory mechanism that applies to all third-party payers. If we don't get some relief from hospital cost escalation, we're never going to get to the point of seeing enough resources channeled to promote these kinds of more market-oriented means of delivering care that could in the long term have the same cost-dampening effect that regulation in the short term should have.

So we are not saying that we want regulation and that should be it forever.

Senator JEPSEN. OK. Do you feel that hospital cost containment is singularly the most important factor that we must get at immediately?

Mr. HACKING. I'm afraid so. In the short term, yes.

Senator JEPSEN. Thank you. Do you have any comment on that, Mr. Goldbeck?

Mr. GOLDBECK. Yes. I think that the concerns you just heard expressed are very legitimate. I think you do need to recognize that there are choices that we can make very quickly, should we decide to do so or have the will to do so. If we believe the record that a capitated system can (a) provide care of at least comparable quality and (b) have a more cost efficient system and (c) are most cost efficient because of the economic incentives in a capitated process, we could decide, instead of spending the past 8 years wondering whether or not medicare should be allowed to have anybody using an HMO, we could decide that medicare will use HMO's, in which case there would be a plethora of HMO's overnight. I mean, there's no concern about whether or not there are enough capitated systems. If the Government is going to pay for care in capitated systems, there will be capitated systems in one hell of a hurry.

I single medicare out because that's the program over which you have authority. The same is true with employers. Employers can decide that instead of having 10 percent, after 9 years, of their population being in HMO's, that they're going to have negotiated care systems, prepaid systems, for 80 percent of their population and reap the benefits.

So we know a lot more than we act upon. The same is certainly true with prevention. I would want to comment on one of the things that you said about Great Britain and that is that in Great Britain you're dealing with a very different cultural orientation toward many of these things as well. It's not strictly a matter of regulation or even whether or not their costs have gone up in the past few years. A great many people in Great Britain are very comfortable with the rationing process. It's not something which has the public marching through the halls of Parliament begging to change and when it was imposed there was no whimper, public or otherwise.

So it's tough to simply say that *x* takes place in Great Britain, therefore it will or won't produce a comparable reaction here. Right now Great Britain is going through a meandering privatization of their health insurance system, not with anybody suggesting that the Public National Health Service should go away, but rather that there could be more balance brought in by having more of a movement of the British United Providence Association or the private insurance systems brought in as a companion program.

So there are certain interesting things going on, and we are moving toward a more unified approach and other countries with unified approaches are moving more toward diversified approaches. And it's a little hard to tell whose model you're supposed to follow.

You asked a question of the first panel about what was happening to insurance and whether or not some of these plans in the private sector would cause increases for certain insured persons, and you didn't get a complete answer. The answer is yes, lots.

We are seeing, in effect, in large group circumstances, the end of traditional insurance. Virtually no companies now are going out and signing new group indemnity plans. They are either self-funding or they're self-administered or both, and they are negotiating packages of care and they are bringing in capitated systems. They are not, in effect, spreading the risks the way traditional insurance is designed and the way your former company made its mark and so forth.

That's a part of history, not the future, and it brings with it a great deal more positive economic incentives, a great deal more consumer awareness, a great deal more choices which are very positive. Also, we have not figured out how to begin to deal with the people who have no choice but to get the very most expensive care—the adverse selection issue—and it's going to be an issue in the public program just as it is in the private program. There's no point in kidding ourselves, though, that it's going to happen. It's already happening.

Senator **Jepsen**. Mrs. White, do you have any comment?

Mrs. **White**. Yes, sir. You talk about cost containment and we really can't limit that to medical care and hospitals in any form. Really, cost containment should be applied to all of us, and this is the thing we talk about in the light of inflation. And I think every one of us in this room and in America today is concerned about inflation because it affects everything. So when we refer to hospital costs, we have to realize that everything that goes into that hospital is inflated from the bath towels, the bed sheets, to the cost of sophisticated equipment which they use. So this is an overall picture which you, as Members of Congress, have an opportunity to look at, to compare, and to see how you best think it should be done.

We in farm bureau would like less government and what we say with that is we like the ones we have elected to use their good judgment through the expertise that's able and provided to them, and then they, working with the private sector and the individuals back in the areas they represent—and I cannot emphasize that enough, sir, that working with the people that you represent—and this gets all areas, all segments, all ages, all professions and businesses—and we believe you, working together with these individuals, that you will be working for the good of the people you represent and likewise for the good of all America.

Senator **Jepsen**. Thank you.

Just by way of summary, I gathered here from the first panel's response that there was a feeling on behalf of industry, as Mr. Califano said, that there was sort of a shell game, a transferring of costs, that the costs didn't go away, and that there is concern on their part that maybe one of the reasons that they were rather receptive to and in fact advocated a national commission was that when these costs were transferred there was a tendency of Government to push them off on the private sector and they in the private sector had to pay for them, and that if they had a national commission they felt that they would have a chance to have some input there and maybe they could neutralize this or at least put into better perspective.

Now, Mr. Hacking, to a little bit of the same degree but with a different result, feels that there may be transfer from the Government to the individual and therefore that in this instance the individuals you represent are on fixed incomes, the great majority of them, but they can't adjust and they don't sell cars and make up—one of them said $350 and the other one said they got $550 and that we need to turn up another 30 to pay the cost and the consumer ultimately pays. You don't have consumers in your organization—I mean, they are consumers, but they have fixed incomes and they are in the retirement years of their lives. So the end result affects your association and your members and the people you represent differently. They have to pay for it, or do without, and the latter is, I think, one of the things you put quotation marks around. Is that correct? Is this analysis correct?

Mr. Hacking. That's correct. The businesses in this country, as they incur higher premiums for the group health insurance they provide for their workers, pass those premiums—either pass them backward on to their workers in the form of lower wages or they pass them forward to the consumers in the form of high prices for the goods and services that those manufacturers produce. That's the way things are being handled today.

The problem that the business community is running into now is that it's becoming a little more difficult for them to shift those costs either backward to the workers or forward to the consumers because they are meeting with resistance. Therefore, in the future, what employers may end up having to do is what we are already seeing happening in medicaid; that is, cut back the extent of the protection that that group health insurance provides for those workers and those workers' dependents through things like the introduction of deductibles, coinsurance—the same thing that the Congress has been doing over the last several years in the medicare projects. And eventually, you will see happening in the private group insurance area what we are now seeing happening in medicare, and that is, as the cost is shifted to the individuals, more and more individuals are going to be precluded from access to care.

Senator **Jepsen.** Mr. Goldbeck.

Mr. Goldbeck. Certainly that is a correct characterization of the fact that business is always in a situation of passing the costs on to somebody else. This is in effect a middle person in that regard. That somebody also includes millions of shareholders and the whole fabric of the economic part of this Nation.

I think it underscores the fact that there is no payer out there in the final analysis to pass something on to, which is why we need to stop kidding ourselves that moving it around or moving Joe's pea around, which is what it is, gets you anywhere. Businesses can only pay that which relates to the revenues that they generate from their products. Congress can only pay that which relates to the taxes that their receive. The rest of us can only pay that which relates to the revenues that we receive from wages or inheritance or some other source.

We are, in effect, a collective payer in that regard. So whether or not one group at one period of time is more successful than another in getting out of paying doesn't lessen the national burden. It won't change. What your job is and our job is collectively is to change those lines, to bend the curve, not to try to get another color up there for a different payer because then the curve goes the same way. That's the difference.

What we don't see yet in the private sector among the big companies—I stress that that is all I'm talking about is the big companies—is a trend toward cutting back on any protection that means anything that is in any way essential. I would stress that there is no reason in the world why we can't have all the medical care that is truly needed in the appropriate settings for the amount of money that we spend.

The problem is that we spend a great deal that doesn't get us anywhere from the health standpoint and is a total waste from an economic standpoint.

Senator **Jepsen**. Well, third payer being the culprit here, according to everybody, has caused a lot of these increases in costs; at the same time the third payer is very much always going to be, for your association, the AARP, the third payer in this instance is a combination of the private insurance and Government—but when you talk about the third payer, the private sector and the insurance business over the years has had to develop and create things to try to have cost control and try to make things meet. In group insurance for years—I think it's still true—but in the years that you said are now gone, Mr. Goldbeck, I remember all we used to talk about was if we handled money everybody would breathe easy and shake hands and congratulate each other if you broke even at the end of the year and you had thousands and thousands of people putting money in and since it's not an exact science like life insurance and so on, if you broke even it was a great success. But when the experience shows that there are some things on the market, then the private sector insurance company had to address that, whether they started with maybe a 10-percent coinsurance or a $20 deductible or they put some limitations on it, but they did that.

But the third payer, when it comes to Government, where for years it seemed as though we had some kind of a reciprocal pump and it just kept providing dollars, and another thing I take issue with in what you said about Congress spending the money they have taken in—Congress always spends all the revenues that they take in plus all the additional money that we could get by with.

So in the hospital cost containment and the runaway health costs, I think if we can sit down honestly and discuss long enough about trying to understand the problem very generally, you could say that one of the third payer folks here is the Government and they seem to use the third payer more removed than most and the doctor, the hospital, the patient—whoever else might be involved—have the Government involved because they come in Friday and they could go home Friday but stay until Monday and say that as long as the Government is paying for it it really doesn't cost anybody anything. That's not true with a private insurance company, but it doesn't cost anybody anything because the Government is paying for it, and without any bad intentions in their heart or any conspiracy involved or any prior planning, the retention of the occupancy in the hospital is going up, and why not stay over the weekend because it doesn't cost anybody anything. The doctor is going to be there anyway and the patient doesn't have to—I'm exaggerating a little bit to make a point, but it happens, according to all the hearings—the few hearings we've had here, when you examine the file, you find case after case and you could probably multiply it by hundreds of thousands where this did happen, that there are 3 or 4 extra days as long as nobody was getting hurt because the Government is paying for it. As Senator Dirksen said, "A million here and a million there, it adds up to some real money after a while," and that's I think maybe why that hospital room red line is one of the reasons why the third payer—Government probably the most far removed third payer, most invisible, and it really doesn't cost anybody.

But to summarize what I'm saying, there is some of the same principles that have been developed in the private sector for trying on an approved business basis to control health costs, some of which are caused by just people being people, just human nature, and you have to apply some business principle and they're going to have to be applied, but when you get to people on fixed incomes, we've got a lack of flexibility, a little different situation.

I guess my question is, without this commission—and I'm not debating that—evidently you weren't represented in that last commission, Mr. Hacking, is that correct?

Mr. **Hacking**. Well, there was no AARP representative on this commission.

Senator **Jepsen**. Well, what way, other than bringing people who represent all facets and phases and parts of this whole problem together and sitting down on a consensus people pounding things out—how would you expect to get this total overview. Could Congress do it? That's what Mrs. White was saying.

Mr. **Hacking**. We would rather see it done in the Congress and in the public forum. As I indicated in my comments on the commission I gave earlier, our problem with the Social Security Commission was that what was fashioned was fashioned in private out of the public view. Now we had commissions before that, but generally other commissions have just simply put something together and sent it up to Congress and then what was sent up was considered in the ordinary process. We just had the Social Security Policy Council send up to Capitol Hill its recommendations for the Medicare Program. Unfortunately, the Social Security Policy Council, their recommendations took a look only at this problem and we think you need to take a systemwide approach to this problem.

So if the commission you're talking about, Mr. Chairman, is going to be in the public, that's going to hear the views of taxpayers, workers, business, the elderly, as well as the insurance companies and providers of care, then fine. What we don't want to see happen is what happened last year with the Social Security Commission.

Mr. **Goldbeck**. Whether fortunately or unfortunately, the reality of the life of the commission and their impact is that those that get something done get it done because it did it in private, and those that just produced a report in public have produced very few outcomes. Again, without suggesting whether that's good or bad, you can look through subject after subject over a 50-year period and that is exactly what has taken place. And so that is why I said in part whether or not a commission is a viable concept has a lot to do with what the expectations are for the outcome of that commission.

Senator **Jepsen**. Do you have a comment, Mrs. White?

Mrs. **White**. Well, the group you've had here this morning, you could take us all coming in representing the different people and maybe individuals and if we all sat down together I dare say we couldn't come up with anything better that would better meet the needs of your people in your home State than you could yourself. You say you get the opportunity to bring people in for discussions, to meet with the groups, to meet with the commission or whatever—you would, but you would not always get the working people and you would not always get the elderly and you would not always get the people who are going to be concerned with your decision.

I just don't think there's any better way to get anything that I want through Congress—and now I'm being personal—than going to my own Representatives and my own Senators and having them know about my cause because I believe they, like you and the other Members of Congress, are more concerned about the total group than anyone else on any commission anywhere.

Senator JEPSEN. Well, I thank you. I would say to you, Mrs. White, that you have raised some valid arguments for allowing farmers and self-employed business men or women to deduct at least half the cost of their health insurance and I am a cosponsor of that in the Senate, and across the board I think there's some hope for that.

I would ask if there are any closing statements or any statements on the record you would like to make before we go on to the next panel?

Mr. HACKING. Yes, Mr. Chairman. I'd like you to look again at this chart. This is where the medicare dollar goes. Medicare, especially medicare part A, is a program that pays hospitals and as you can see from what is happening in terms of hospital room rates relative to what is happening to the Consumer Price Index, it is the cause of the escalation in hospital costs that is impacting on the medicaid program and driving that program very rapidly toward insolvency.

Until something is done about hospital cost escalation, the crisis in medicare cannot be avoided. It can be deferred. You can raise taxes on workers and consumers, but it cannot be avoided. The deficit will simply build over time and the Congress will have to over time transfer more and more private and public wealth into the Medicare Program to continue to pay hospitals.

Senator JEPSEN. Mr. Goldbeck.

Mr. GOLDBECK. I would certainly agree with that. I think that our message would be that there is not an advantage to the economy of this country, basically the jurisdiction of this committee, to segment this economic problem into one that is medicare only or medicaid only or State only or business only, but rather one which is a total economic problem that will indeed respond to economic change and economic incentives.

The problems that we have now are a response to a set of economic circumstances that we wrote collectively. If we wish to bring about changes in those trend lines, if we want to change the pie, then we have to change the rules. That means we are overtly restructuring one of the most ironically economically successful industries in America today and we have to be willing to do that and not pretend that we're talking about a little bit of benefit here or a little bit of eligibility there. We're talking about restructuring the economics of a major industry and decide that that warrants national attention. We think it does and we think this committee is to be commended for helping move in that direction.

Senator JEPSEN. Mrs. White.

Mrs. WHITE. I would like to say the same thing. You do need to be committed. I think Congress is working at this. All of us recognize the fact it's costs everywhere to every individual, regardless of what station in life they are. Is the concern about the cost of Government, the cost of living wherever they are. Talk about running out of money, it's like the little boy who said to his mother, "Don't worry about losing your billfold, it was just money." Well, it used to be just money, but it isn't so any more. The Government has no money, the people have no money. So we are concerned in general about the conditions of this country.

So I will repeat what I said already several times, I don't think anybody can solve these problems any better than Congress working with the people, and I do say you are working at it the best you can with the problems you have and the people you have out there showing the interest, and I would like to encourage more people who are concerned about everything we've discussed this morning to get involved and let you hear from them, rather than waiting until the time for criticism. So we appreciate it and any way farm bureau can work with you we would be glad to. Thank you.

Senator **Jepsen**. I might say that you're three of the most dynamic witnesses I have ever had appear. I appreciate it and I mean that very sincerely. You presented a lot of food for thought and you have told it like it is and I appreciate that. Thank you for coming and we look forward to your input as we move along. It is something we will address because we must this year and hopefully we can do it with a little more of a broad brush rather than just focusing in on the medicare and medicaid programs. It is much broader than just that and your suggestions and your observations have contributed to that. Thank you very much.

I would call the next panel: Mary Suther, Dr. Nelson, and Jack Owen. Mary Suther is executive officer of the VNA of Dallas, TX, and will be testifying on behalf of the National Association for Home Care, the largest representative of home health care agencies. I think it's very appropriate and very interesting that we have just had quite a dramatic exchange here and discussion on hospital cost containment and I didn't hear anything said about maybe we ought to do things different. Maybe it's the home health care that can alleviate some of this. We will now hear about that I'm sure.

Dr. Nelson will be testifying on behalf of the American Medical Association, and Jack Owen will be representing the hospital community.

At this point in time I'm going to go vote and so I will declare a 5-minute recess and you can all rest and get better acquainted and I will be back in about 5 minutes. We will recess for that time.

[A short recess was taken.]

Senator **Jepsen**. I will call this hearing to order.

Mary Suther, executive officer of the VNA of Dallas, TX. Mary will testify on behalf of the National Association for Home Care, the largest representative of home health care agencies. Dr. Alan Nelson, board of trustees, American Medical Association, will be testifying on behalf of the AMA and will give the view of physicians; and Mr. Jack Owen, executive vice president, American Hospital Association.

We'll start from my left and go right and, Mr. Owen, you may proceed. Your prepared statement will be entered into the record and you may proceed in any way you so desire.

STATEMENT OF JACK OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. **Owen**. Thank you, Mr. Chairman. I am Jack Owen, executive vice president of the American Hospital Association, and I am going to refer to my testimony but I'm going to summarize it and keep it rather short.

I'd like to start off by just commenting on a couple of things that came up in previous panels if I might. I heard Mr. Califano talking about the problems and I think one thing he did say, that I would certainly agree with him on that during the 1960's the whole emphasis on health care was access, one level of care, the best care, the highest quality, and everybody was supposed to get that high level of care. And I guess we did too good a job because that's what drove costs up as much as anything else.

The incentive was to provide care for anybody who came and, as you said, the Government paid for it, and those are the rules with which we played for almost 20 years.

Now we are faced with a completely different set of circumstances. We know we can't afford to provide care for everybody. There's just not enough money there, so the hospitals were asked that we turn around and do a different approach and I'm pleased today to be able to report that I think we are making progress in the year's time that Congress has had to change the incentive system.

I would like to just point out what's happened in the last year and why we believe the incentive system is starting to work, regardless of what you see. I have to again refer to Mr. Hacking pointing to the red line, the hospital room line, and he said that was driving up the medicare costs. I would remind you, Mr. Chairman, that medicare does not pay hospital room rates, never has, and that the room rates that are there are set by hospitals but with 94 percent of the people being third party paid for, very few of them ever pay the room rates and it's a figure that shows up constantly which really has very little meaning when it comes to whether inflation and hospital costs have increased or not. I think we have to keep that in mind. Blue Cross doesn't pay room rates. Some insurance companies do. Medicare and medicaid don't.

I think we have to also, if I could comment just a minute on the shifting, because there seems to be an awful lot of concern—both the gentlemen from Ford and Chrysler and Mr. Goldbeck from the Business Council talked about the shifting of costs.

First of all, I'd have to say that hospitals don't shift costs. They shift where they get their revenue from. If we have three patients in the hospital and Dr. Nelson is a full payer and this gentleman isn't and I'm a medicare patient and this gentleman doesn't pay anything, his costs are going to be the same as our costs, but we have to get some revenue to pay for that. And the real issue is, where does the hospital get the money to take care of the people who aren't going to pay?

The implication this morning was that medicare was the culprit that was shifting the costs to the private sector. I don't believe that. I don't think any statistics so far are showing that medicare is the culprit. Medicaid, however, is. Medicaid, which is being cut back by States across this country, are leaving a lot of people who are poor and needy uncovered and they're not being covered by the Ford Motor Co., or the Chryslers or any of the business groups, and the AARP and other groups don't want to pay for them either, but when that disadvantaged person comes into the hospital for that appendicitis or broken leg, the hospital takes care of him. The hospital doesn't say, "I'm sorry, we can't take care of you because we've got to shift where we get the revenue from, because we're going to have to pay for food, we're going to have to pay for people to take care of you and pay for the drugs." Nobody is giving those supplies to us. So that somebody, no matter what kind of a system we talk about, we're going to have some poor, disadvantaged people and there will be some revenue shift. There's got to be. There is in every business.

So with that, I would just like to point out very quickly if I could what we see happening in regard to the incentive system that is now underway with medicare and why we think it's going to have some powerful incentives on the rest of the private sector as well.

During 1983, the rate of increase in total hospital expenses slowed from about 15.8 percent in 1982 to 10.2 percent in 1983. So we had about a 5-percent decrease or slowing down in the hospital expenses. The reduction in the rate of increase in inpatient expenses has been even greater, from 15.6 percent in 1982 to 9.6 percent in 1983. We are now down below the double digit inflation.

This substantial reduction cannot be explained solely on the basis of demand or marketplace pressures. As trends in hospital employment and length of stay indicate, a substantial part of the industry's performance in 1983 is due to improvements in hospital efficiency in both the production and use of hospital services. That's what this system was designed to do, to increase production and efficiency.

During the past several years, a trend toward slower growth of hospital employment has been established. The increase in hospital employment was dramatically lower in 1983 than in 1982. Total employment rose 1.4 percent in 1983 compared to a 3.7-percent increase in 1982. The increase in staffing ratios was also smaller in 1983 than in 1982, indicating that the slower growth of employment was not entirely due to slower demand growth.

Slower growth in the volume of hospital services also has moderated historical trends in hospital expenses, contrary to what many of our critics are saying that this line is just going up out of sight. Total admissions declined a half of 1 percent during 1983 after remaining stable in 1982.

Now if you think about that for 1 minute, admissions of patients 65 years of age and older increased 4.7 percent against about 5 percent during the historical trend each year because of the number of people who are turning over into the age 65 group. The length of stay for patients 65 years of age and older was down sharply, 4.5 percent, resulting in almost no net increase in total patient days for patients in this category. In other words, even though the increase in the trend of admissions is going up slightly, because we were able to cut the length of stay, the total days for medicare in 1983 remained stable and there was no increase for the first time. These annual trends were even more apparent in the fourth quarter of 1983. We just started the DRG program on October 1, 1983, so that was the fourth quarter. Admissions of patients 65 years of age and older increased by less than 1 percent in that quarter, while the average length of stay fell 5.5 percent. So something has happened out there and the incentive under the DRG system is starting to work.

Slower growth of utilization was not limited to the over-65 population. I think this is important from the standpoint of what these panels are talking about. They seemed to think the only thing happening has to do with medicare. Admissions for patients under the age of 65 was down sharply during 1983, 2.8 percent. Thus, we had a 2.8 percent decline in the rate of admissions of those under 65, which means that the people that are on Blue Cross and commercial insurance and so forth that are not a part of medicare are actually using hospital care less. And that trend is continuing in the first quarter of this year.

Now the significance of these trends is readily apparent. First, hospitals are responding to the incentives created by both prospective pricing and the system of per case payment establishment. Medicare length of stay is down, the increase in hospital staffing levels is slowing, and the overall increase in hospital costs is moderating. Second, because real changes are occurring in hospital performance, savings are being generated not only for the medicare program but also for other payers as well. This has been achieved without a monolithic system of payments covering all third parties and patients, and without a burdensome regulatory apparatus. It is critical that hospitals have the opportunity to continue their response to incentives created by prospective pricing and that the system not be manipulated to produce arbitrary, short-term reductions in Federal outlays.

I don't quite understand Mr. Hacking's point that we're only going to have regulations for a short time. I just don't see how you can have regulations for a short time and then take regulations away. I think other countries have shown that that doesn't work.

Now just in summary of what else is happening, I would say that, in addition to the medicare program which we're all concerned about, we have seen the advent of PPO's. These are preferred provider organizations which now there are some 84 hospitals that are involved in these, and in a recent survey that we've just completed, over 700 hospitals are now anticipating and investigating participation in these preferred provider organizations.

Now these are organizations in which business and industry negotiate with the hospital to take care of their employees at a particular rate. It's a very competitive approach and it's working. It's a big advantage to the employee groups.

We have seen some technological advancement and these both increase and decrease costs and we have to recognize that. But many times, they enhance the ability to treat patients. The CAT scan would be the most famous piece of equipment that we've discussed over the past few years. The ability to look inside a person's body without having invasion through surgery was a great step forward in diagnostic treatment of the diagnostic procedures for a patient and without the technological advances we wouldn't have that. So that's there.

But I think we have got to be careful as we talk about we're going to save money and we're going to cut the costs. We can't forget the accessibility, and you referred to it very briefly when talking with Mr. Califano and the gentleman from Ford when you said the problem that you're reaching and seeing in Iowa as you cut back is that people are beginning to say, "Hey, wait 1 minute. We can't get the care we want," and they're beginning to complain. Because we will continue to keep the quality, we can do that, but we may have a problem keeping accessibility that we've known in the past if no one wants to pick up their share of those who can't pay.

I would just conclude by saying that the medicare pricing policy, which right now is a fair policy, is going to work to hold down total medicare costs of health care and it's going to help the rest of the economy as well, but the price has got to be fair. When the price isn't fair, then we're going to see a shifting of hospitals needing to get revenues from other patients. The shifting that's taking place now, the kinds of shifting that Ford Motor Co. represented—and you asked him a very pertinent question and that is, why are those people 65 to 69 up, if they're working there, why should they be part of the medicare program? That's a good question. It's those kind of shifts which nobody wants to take that are going to be worse if the price to the hospitals are below what the fixed costs are and we must continue to deliver the care.

Mr. Hacking and AARP and everybody else is saying more care and more care, but where's the money? I think you have to be very careful to watch what happens to accessibility and I think we have to be very careful as we watch medicare what happens to medicaid. The two have been tied together for so long, if States pull out of the medicaid program, it becomes more difficult for hospitals to take care of the poor and needy.

With that, I would conclude my statement, Mr. Chairman.

[The prepared statement of Mr. Owen follows:]

PREPARED STATEMENT OF JACK OWEN

Mr. Chairman, I am Jack Owen, Executive Vice President of the American Hospital Association (AHA). The AHA, which represents over 6,100 member hospitals and health care institutions, as well as more than 38,000 personal members, is pleased to have this opportunity to present its views on health care cost issues to the Joint Economic Committee.

INTRODUCTION

I am particularly pleased to be here today, as this hearing provides an opportunity to report on the substantial progress that has been made by the hospital industry in reducing the rate of increase in hospital costs over the past year. This hearing is also an opportunity to discuss the significant changes that are occurring in the hospital industry in response to changing demands by both public and private payers. These changes offer the best opportunity for ensuring that costs are consistent with consumer needs and expectations.

For several years the American Hospital Association has advocated the use of incentives to bring about hospital cost containment. The incentives-based approach stimulates the industry to develop new ways of delivering services at lower cost, and encourages hospital managers to be responsive to both consumer and payer demands. The private sector has adopted elements of this approach, with substantial activity occurring in the development of private sector prospective pricing systems, preferred provider organizations and selected provider contracting, and innovative health insurance packages. Medicare's prospective pricing system provides an example of how powerful the incentives approach can be when adopted by a major payer. In addition, it provides an illustration of the issues that must be resolved if the incentives-based approach is to be successful.

The AHA continues to believe that the incentives approach is superior to the use of regulation to control costs. A reliance on regulation will discourage innovation that is essential if high quality health care is to continue to be made available to the public at a cost that the public is willing and able to pay. Regulatory approaches, particularly when applied across the board, inhibit the ability of providers to respond to the unique needs and expectations of specific consumer groups and employers.

1983 PERFORMANCE

During 1983, the rate of increase in total hospital expenses slowed from 15.8 percent, in 1982, to 10.2 percent, in 1983. The reduction in the rate of increase in inpatient expenses has been even greater: from 15.6 percent in 1982 to 9.6 percent in 1983. This substantial reduction cannot be explained on the basis of demand or marketbasket pressures. As trends in hospital employment and length of stay indicate, a substantial part of the industry's performance in 1983 is due to improvements in hospital efficiency in both the production and use of hospital services.

During the past several years, a trend toward slower growth of hospital employment has been established. The increase in hospital employment was dramatically lower in 1983 than in 1982. Total employment rose 1.4 percent in 1983 compared to a 3.7 percent increase in 1982. The increase in staffing ratios was also smaller in 1983 than in 1982, indicating that the slower growth of employment was not entirely due to slower demand growth.

Slower growth in the volume of hospital services also has moderated historical trends in hospital expenses. Total admissions declined 1/2 of 1 percent during 1983, after remaining stable in 1982. Admissions of patients 65 years of age and older increased 4.7 percent during 1983, slightly below the historical trend. Length of stay for patients 65 years of age and older was down sharply--4.5 percent--resulting in almost no net increase in total patient days for patients in this category. These annual trends were even more apparent in the fourth quarter of 1983, with admissions of patients 65 years of age and older increasing by less than 1 percent, while the average length of stay for these patients fell 5.5 percent.

Slower growth of utilization was not limited to the over-65 population. Admissions for patients under the age of 65 was down sharply during 1983--2.8 percent--thus, continuing trends established in 1982.

The significance of these trends is readily apparent. First, hospitals are responding to the incentives created by both prospective pricing and the system of per case payment established by the Tax Equity and Fiscal Responsibility Act. Medicare length of stay is down, the increase in hospital staffing levels is slowing, and the overall increase in hospital costs is moderating. Second, because real changes are occurring in hospital performance, savings are being generated not only for the Medicare program but also for other payers as well. This has been achieved without a monolithic system of payment covering all third parties and patients, and without a burdensome regulatory apparatus. It is critical that hospitals have the opportunity to continue their response to the incentives created by prospective pricing and that the system not be manipulated to produce arbitrary, short-term reductions in federal outlays.

PRIVATE SECTOR DEVELOPMENTS

Although adoption of prospective pricing by Medicare is the most dramatic change in the hospital industry, other changes are taking place as well. After Medicare, possibly the most widely discussed new idea in health care is that of preferred provider organizations (PPOs). A survey conducted by the American Hospital Association and sponsored by the Health West Foundation in late 1982 and early 1983 identified 84 hospitals involved in a preferred provider organization and more than 700 hospitals that were considering involvement in a PPO. A follow-up survey conducted in July of 1983 identified 40 operational PPOs, most of which involved two or more hospitals. The key characteristic of these organizations is their use of unique combinations of features to meet the particular needs and demands of an employee group. Both the services covered and the ways of delivering those services vary from plan to plan, which ensures a high degree of responsiveness to the particular groups involved.

With increased emphasis on health care costs, many employers are re-examining their health insurance coverage to explore alternative ways of providing financial protection to their employees while encouraging the cost-effective use of hospital and other health care services. Employers also have shown substantial interest in the PPO concept. Many employers are actively pursuing the development of PPOs as an alternative to more conventional health insurance. In addition, employer/provider coalitions continue to be one promising means of bringing about the effective collaboration of providers, employers, and organized labor in an effort to contain health care costs. The Community Programs for Affordable Health Care project, sponsored by the Robert Wood Johnson Foundation, is providing examples of innovative efforts to develop local health care financing and delivery systems that are responsive to community needs and resources.

LONG TERM ISSUES

The 1983 trends clearly indicate that hospitals are responding to new incentives. It is important to recognize, however, that financing systems have purposes other than simply containing costs. In recent years, attention has drifted away from a concern with access to care and toward an exclusive focus on budgetary issues. Although important, budgetary issues should not dominate the formulation of health policy by the federal government, state government, or by the private sector. It is unrealistic to expect that improvements in efficiency can be used to "fund" technological advances. Efforts to do so inevitably result in significant changes in the services available to both public and private patients.

Technological advances can both increase and decrease costs. Many technological advances increase the demand for care as they enhance the ability of medicine to treat illness and extend the quality and length of life. Since the enactment of the Medicare program, there has been a steady increase in the life expectancy of the elderly that has tended to parallel the increase in the cost of the Medicare program. The U.S. Office of Technology Assessment has identified neonatal intensive care as a technological advance that has improved the chances of survival for premature and high risk infants. Similarly, five-year survival rates for childhood leukemia victims have improved tremendously in recent years. In examining hospital departmental staffing trends, we find that the fastest growing departments have been those using more advanced technology and higher-paid therapeutic and diagnostic services. Providing these services raises total costs, but at the same time improves patient outcomes and health status.

The implementation of the Medicare prospective pricing system provides an opportunity to examine the relationship among the objectives of cost-containment, quality of care, and access to services. If the new system is manipulated to simply produce short-term budget savings, the inevitable result will be reduced access to services by the elderly. A successful Medicare payment system requires prices that are adequate--only adequate prices will enable the program to meet its objective of containing costs without adversely affecting the ability of the Medicare population to receive necessary high-quality services.

In addition, to be successful, Medicare's prospective pricing system also must establish prices that are fair. If it does not, hospitals may well be penalized for providing technologically advanced services or developing regional referral networks. The AHA has urged both the Department of Health and Human Services and the Congress to carefully examine the equity of the Medicare prospective pricing system, and identify any potentially adverse consequences of moving quickly to uniform national rates of payment. Problems already have been identified for certain rural hospitals that function as referral centers and offer a comprehensive range of services. Although these hospitals offer services that are comparable to those found in most cities, their payment often ranges from $700 to $900 per case less than their urban counterparts.

In an effort to address equity problems, the American Hospital Association has urged Congress to study the concept of setting Medicare prices unique to each DRG based on a combination of a uniform national rate of payment and a hospital-specific rate of payment. For those DRGs that describe a uniform group of patients, the price will reflect the national average. The prices of those DRGs exhibiting substantial variation in costs, and in which severity of illness is likely to play a major role in determining the cost of treatment, would be heavily weighted toward a hospital-specific rate. We believe this approach has great potential for improving the equity of the Medicare prospective pricing system, while preserving its incentives, until such time as the DRG system on which prospective pricing is based is adequately refined.

We have identified a number of other problems, including deficiencies in the wage index used to adjust prices for regional variations in the cost of labor and have urged Congress to make necessary statutory modifications to prevent undesirable changes in the hospital industry that will be necessary if hospitals are to avoid unjustified financial shortfalls in the short-term.

CONCLUSION

The Medicare prospective pricing system is demonstrating the effectiveness of the incentives-based approach to containing health care costs. Experience to date suggests that a Medicare-only system can work to contain both Medicare expenditures and total costs. The Medicare system also is providing an opportunity to examine the complexities encountered in trying to change the incentives that influence both hospital and patient behavior while providing adequate and fair rates of payment.

In evaluating the performance of the Medicare system, the American Hospital Association urges members of Congress to keep in mind the issues of costs and of the kind of Medicare system that will be available to meet the needs of the elderly now and in the future. If the Medicare system is implemented with a firm commitment to establishing prices that are both adequate and equitable, the AHA believes that both the public and the providers will be well served. In the private sector, the AHA urges Congress to give providers, insurers, and employers the time needed to work out the innovative methods of providing a range of services that are responsive to the needs of particular groups at a cost that those groups are willing to pay.

Senator JEPSEN. I thank you, Mr. Owen.
Dr. Nelson.

STATEMENT OF ALAN R. NELSON, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION, AMA

Dr. NELSON. Thank you, Mr. Chairman. My name is Alan Nelson. I'm a private practitioner in internal medicine in Salt Lake City. I'm also on the AMA board of trustees and with me is Mr. Ross Rubin from the department of legislation of the AMA .

The health care sector has become a major component of the American economy. In addition to the frequently cited figure of 10 percent of the gross national product, you also have to remember that some 7 million people are employed in health care, 5.2 million full-time equivalent positions. As a matter of fact, the health care industry ranks second among the Nation's industries behind retail trade. Each office-based physician employs an average of 2.1 full-time equivalent nonphysician personnel.

In the not too distant past, public policy in the health area was geared toward expansion of the health care system and promoting higher quality health care and wider public access to health services.

Through efforts in both the public and private sector our Nation has developed a medical care system that is a benchmark against which other medical systems throughout the world are measured. Health status in the United States, as a matter of fact, improved to the point where now we're increasingly worried about the cost of health care, in addition to the more fundamental concerns of quality and access.

But it's important in any discussion about the impact of health costs to talk about what that investment by our society has purchased.

The life expectancy of Americans has increased from 69.7 years in 1960 to 74.5 years in 1982. Infant mortality has been reduced to a record low of 11.2 per 1,000 live births, less than half the figure in 1960.

Since 1970, deaths from heart disease have declined by 25 percent and deaths from stroke have declined by 40 percent. These advances have come through major technological advances as well as through improved access to care and changes in lifestyles.

Medical advances have greatly increased the quality of health care available to Americans and the quality and length of their lives. Furthermore. a healthier population is more productive with less workdays lost to illness and with reductions in percentage of individuals who are disabled from certain chronic conditions.

Mr. Chairman, many individuals now appear concerned that expenditures for health care exceed 10 percent of gross national product and while this is a substantial portion of our total national product, it must be remembered that consumer expenditures for alcohol and tobacco were 3.8 percent of consumer expenditures in 1981 and that recreation accounted for 6.4 percent. Taxes accounted for 20.48 percent of gross personal income. It must be recognized also that 10 percent of gross national product for health care is not a magic figure and could justifiably increase over the years as medical care provides new benefits to our aging population.

If we take the curve of gross national product and eliminate all the unnecessary care—that is, we eliminate on a one-time basis all overutilization—we rationalize the demand and we eliminate all the fat that it's possible to eliminate—we would have a one-time aberration in the curve. Perhaps it would be slanted like this [indicating], or flat or perhaps even go down. But then, as our technological capability resumes and continues as it has in the past, then presumably that curve would again follow the same line.

As a matter of fact, if we want to find the culprit for the curve that describes our health care costs, perhaps the single most responsible individual would be Dr. Fleming, who discovered penicillin, or Mr. John Crapper, who invented the flush toilet, because prior to the antibiotic era and the area of sanitation people died in infancy or as children or they died at home because there was very little we could do for them in the hospital, and it didn't cost anybody anything. As we live longer, as our technological capabilities improve, as a consequence, costs go up.

I had the chairman of the board of one of our major mutual insurers tell me that the health care costs for two children in the neonatal intensive care unit were several hundreds of thousands of dollars for two children. He demanded to know what we were going to do about that. I had to ask him what he wanted us to do, did he want us to let 2-pound babies die? If the answer is no, if we want 1½-to 2-pound babies to live, then we can't criticize the health care system for providing the technological capability that permits that.

We have to make conscious decisions about priority, and as I conclude my remarks, I will return to the comments of former Secretary Califano who called for a national health policy.

We don't provide the same care now that we did in 1950. I received a phone call yesterday morning at 7 a.m. from a young woman patient who said that her insulin pump for her diabetes had lost its program and she wanted to know how to reinstitute the program that permits her to have her insulin around the clock in small doses with larger doses prior to each meal. Now my patient also had laser treatment so her eyesight is good, her diabetes management control is much better than it has ever been and she's substantially better off than her sister who's also a patient of mine who is blind, has diabetes, and is awaiting renal dialysis and a transplant. Unfortunately, some of our technological capability didn't come along early enough for her sister, but we can't deny that most of the services that I provide as an internist weren't available 19 years ago when I started practicing. Most of the drugs that I prescribe, most of the tests that I order, weren't available. Of course, the cost will be different because the product is different.

We also have to remember that health care costs aren't immune from outside market forces and general inflation. Hospitals and other health care settings are labor intensive. Therefore, inflation in wages and other general expenditures also contribute to the increasing costs.

Finally, it's staggering to observe that between 1983 and 2025 the growth of the population will be 30 percent. In that same timeframe, the growth of the population over 65 will be 200 percent, and the growth of those over 85 will be 300 percent. As we've already observed, the elderly have more health problems, and consume more health resources. Unless we decide to ration care, health costs will go up.

Last month the AMA sent a letter to every physician in this country, whether they were AMA members or not, and urged each to voluntarily freeze his or her fees for a 1-year period and to continue to take into account the financial circumstances of our patients and to accept reduced fees when warranted and be considerate of the needs of our patients to avoid increasing the financial burden, particularly of the unemployed, the uninsured, and those under medicare.

And I have to be proud of the response from the State medical societies with the medical associations of Alabama, Arkansas, California, Delaware, Florida, Georgia, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Oklahoma, Texas, Utah, Vermont, Washington, New York, Virginia, and Wisconsin, just in the short period of time since we called for a freeze, having ratified that call and pledged their cooperation. National medical specialty societies have also adopted the freeze, including the American Academy of Neurology, the College of American Pathologists, the American Society of Internal Medicine, and several other specialty societies.

We believe that the great advances in health status of the American people has occurred because this country has devoted necessary resources to the health care sector and has kept inappropriate Government intrusion into the medical marketplace to a minimum. And we believe this policy should continue.

We also believe that great strides can be made by encouraging the American public to prevent illness through adoption of healthier lifestyles, such as improved diets, reduce smoking, and exercise.

The Federal Government can play a valuable role in encouraging such activity.

It should be remembered that a significant reduction in health care costs could have severe economic effects through decreased employment and the spinoff spending generated by health care income. As a matter of fact, since prospective pricing went into place there have been reports of hospitals initiating significant layoffs of personnel causing great concern within our communities, particularly in the relatively small communities.

America's physicians stand ready to cooperate in our Nation's continuing commitment to ensure the highest possible level of health care for all people and we urge you to keep in mind, while expenditures for health care have increased greatly over the past 30 years, the Nation and the economy as a whole have received significant benefits from these expenditures. These benefits relate to improved health status, longer life expectancy, and improved quality of life. Productivity also increases when absenteeism from illness is reduced and when chronic conditions can be controlled with workers continuing in their jobs.

The American Medical Association is spending $3 million and has been at work for over a year and will complete by the end of 1985 its health policy agenda for the American people. The project brings together representatives from 150 groups, including Government, labor, business, hospitals, medical specialties, consumers, insurers, in the development of a national health policy which will be not the property of the AMA. The AMA is the facilitator and we are paying for the work to take place and staffing it, but the output of the health policy project will be a rational and coherent national health policy. This project has already completed the work on the basic principles, 160-some-odd basic principles that cover the range of issues from medical education and scientific inquiry on one end to payment for services on the other.

The work groups are now in the process of defining specific policy issues within each of these basic principles and out of this will come some kind of consensus, at least a framework, so that in the future our health policy decisions are not made in a haphazard, isolated way, but through some coherent framework.

Much of the policy agenda, principles, and issues, will be supported by the AMA and become policy of the AMA. Much already is policy. Some, undoubtedly, will not be acceptable to the AMA since it represents a consensus of all groups participating.

I would think that Mr. Califano's expectations for a national health policy to be developed within 1 year is overly optimistic based on our experience.

In either event, the AMA is committed to the development of a health policy agenda that, among other things, will address that question that I raised about the curve after we've eliminated all the fat, and what can be done then and what should be done so that society can serve its health and other obligations to feed and clothe and house our citizens. The work of that project will be the property of the American people. It will be our contribution to assisting and solving some of these difficult questions.

Thank you.

[The prepared statement of Dr. Nelson follows:]

Prepared Statement of Alan R. Nelson, M.D.

Mr. Chairman and Members of the Committee:

My name is Alan R. Nelson, M.D. I am a physician in the practice of Internal Medicine in Salt Lake City, Utah, and I am a member of the Board of Trustees of the American Medical Association. With me today is Ross Rubin, Director of AMA's Department of Federal Legislation. The American Medical Association is pleased to have the opportunity of presenting its views on the subject of health care and its effect on the economy.

Mr. Chairman, the health care sector has become a major component of the American economy. In addition to the frequently cited figure of health care income contributing to over 10% of the Gross National Product, the health services industry is responsible for employing 5.2

million full time equivalent positions and ranks second among the nation's industries behind retail trade. Each office-based physician employs an average of 2.1 full-time equivalent non-physician personnel. In the health care sector, for 1982 hospital care accounted for 42% of total expenditures and physicians services accounted for 19%. The balance of expenditures consists of nursing home care (8.5%), drugs (6.9%), dentists services (6%), research and construction (4.4%), program administration and insurance (3.9%), other professional services (2%), eyeglasses and other appliances (1.9%), government public health activities (2.6%), and other health services (2.3%).

The health care sector of the economy also represents a growing part of our economy. This sector is highly labor intensive and in 1982 showed a 4.3% increase in total private employment and a 4.8% increase in growth work hours. Unemployment in the health care sector in 1982 was limited to 4.5%. Hospitals and other providers of health care services are major sources of employment and income for the local economy.

Health care issues impact to a greater and greater degree in our public policy debates. Federal and state governments confront health issues directly through funding for and administration of the Medicare, Medicaid, other health benefit programs, and other public health activities and indirectly through a concern for the general economy as a whole. Medicare costs are now perceived as a major problem threatening the stability of the program.

Corporations are also becoming more concerned with achieving economies in health care payment and delivery systems in light of their commitment to provide comprehensive health benefits coverage to their employees. Some industry is now concerned that fringe benefit costs place American business at a disadvantage with foreign competitors having lower total labor costs. Clearly, the health area is viewed as a sector of the economy that is causing problems with cost concerns becoming the paramount issue in the health debate in both the public and private sector.

This was not always the case. In the not too distant past, public policy in the health area was geared toward expansion of the health care system and promoting higher quality health care and wider public access to health services. The federal government sponsored grants to promote hospital construction through the Hill-Burton program. Private health insurance was promoted through various provisions of the tax laws designed to subsidize health insurance purchases. Government and the private sector established major research programs aimed at eradicating or ameliorating dreaded diseases. Programs were established to increase capacity to train health professionals. The economic signals of the sixties and seventies were directed toward expansion of the health care system and increased resources to provide more and better services.

Through these efforts our nation has developed a medical system that is a benchmark against which other medical systems are measured. Health status in the U.S. has, in fact, improved to the point that allows us to have the relative luxury of worrying about the cost of health care in addition to the more fundamental concerns of quality and access.

Advances in Health Care

Mr. Chairman, it is important that in any discussion about the impact of health care costs on the economy we not lose sight of the great advances that have characterized our nation's health care system and the benefits that have been provided to our society.

The life expectancy of Americans has increased from 69.7 years in 1960 to 74.5 years in 1982. Infant mortality has been reduced to a record low of 11.2 per 1000 live births, less than half the figure in 1960.

Today, through the development of and widespread availability of vaccines, polio has been virtually eliminated, the incidence of mumps has fallen from over 150,000 cases as recently as 1968 to 3,285 last year, and cases of measles have declined from 481,530 in 1962 to 1,436 in 1983.

Since 1970, deaths from heart disease have declined by 25% and deaths from stroke have declined by 40%. These advances have come through major technological advances including open-heart surgery, pacemakers, new drugs, and greater public consciousness of the importance of proper exercise and diet. While cancer remains a major threat, patients are living longer after treatment and many forms of cancer, formerly viewed as inevitably leading to death, are now curable.

The modern miracle of transplant surgery provides life and hope to people otherwise facing death, prolonged hospitalization or deteriorating quality of life. New hearts are transplanted into 100 Americans per year and 5000 people receive transplanted kidneys. In 1983 there were 23,000 cornea transplants returning sight to those whose vision was severely impaired.

Artificial organs are being developed for use when human organs are unavailable. Artificial kidneys are being developed as well as artifical pancreases. Of course, we all became dramatically aware of the artificial heart which kept Dr. Barney Clark alive for 112 days. Artifical hip joints have become almost routine relieving over 65,000 patients of chronic pain last year.

New diagnostic devices such as CAT scanners, ultrasound, and nuclear magenetic resonance have greatly enhanced our ability to make rapid and more accurate diagnoses. These technologies also obviate the need to use more risky invasive diagnostic procedures.

These medical advances have greatly increased the quality of health care available to Americans and the quality and length of our lives. Furthermore, a healthier population is more productive with less work days lost to illness and with reductions in percentage of individuals who are disabled from certain chronic conditions.

The 10% of GNP Threshhold

Many individuals now appear concerned that expenditures for health care exceed 10% of GNP. While this is a substantial portion of our total national product, it must be remembered that consumer expenditures on alcohol and tobacco were 3.8% of consumer expenditures in 1981 and that "recreation" accounted for 6.4% of consumer expenditures in that year and that taxes accounted for 20.48% of gross personal income. (In 1981 medical care represented 10.6% of consumer expenditures.) It must also be recognized that 10% of GNP for health care is not a magic figure and could justifiably increase over the years as medical care provides new benefits to our aging population.

Mr. Chairman, we all often hear people speak fondly of "the good old days" with regard to the construction of our cars, houses, the state of our schools and teachers, etc. We often hear contrasts between health care costs in the '50s and '60s compared to current costs. We hear that spending on health care has increased from $27 billion in 1960 to $356 billion last year--from 5% of the Gross Natonal Product to over 10%. We are told that the cost of medical care has increased faster than the inflation rate. In such simplistic comparisons is the connotation that today's health care is the same as in those past decades and that costs have gone up because of waste and irresponsibility in the health care industry.

Such is not the case. We could turn back the clock and provide 1950 and 1960 health care to the American public. While this approach would certainly reduce costs, the consequences to the health of the American public would be dramatic. Without kidney dialysis and transplants, tens of thousands of Americans who are alive today, leading productive lives, would be lost. If we went back to the '50s and '60s technology, thousands more who have been cured of cancer would not be alive today. Without coronary bypass surgery, individuals with blocked cardiac arteries would either be disabled or subject to a higher frequency of strokes and heart attacks.

I point these facts out today not to say that all increases in health care costs are justified but to highlight the fallacy of using comparisons to another era as a basis for criticizing today's system.

The remarkable achievements in medical care have not come without cost. I have already mentioned the financial strains that our commitment to quality health care for all are placing on government and private sector alike. In addition, medical advances have created profound new moral dilemmas for which we still grope for answers. Our new ability to keep terminally-ill patients alive for indefinite periods of time and our ability to maintain life in severely-handicapped infants are issues that will cause much societal and individual soul-searching in the years ahead. The moral and economic consequences of these advances in medical technology are profound and must be addressed. However, they should be addressed within an atmosphere of reasoned policy determinations considering all elements of society's obligations to its members, not within the context only of economic crisis and budget cuts or an arbitrary percentage of gross national product.

Worldwide Cost Increases Noted

In addition, it is important to point out that the United States is in no way unique in the amount of resources allocated to health care. Available data show that the average annual rate of increase for health care expenditures experienced in the United States was less than that seen in many western nations. The average annual rate of increase for total health care expenditures in the United States from 1978 to 1980 was 14.7%. However, this figure was higher in the United Kingdom (20.8%) and France (16.6%). Also, the analysis of national health expenditures in nine countries indicates that the percentage share of GNP for health care expenditures in the United States is not out of line with that of the other countries. While the share of GNP in the United States was 8.7% in 1976, Netherlands, West Germany, France, and Sweden all had percentage expenditures greater than 8.2%; Australia, Finland, and Canada all had expenditures greater than 7%; and only the United Kingdom had an expenditure that was less than 6%. It must also be remembered that in Great Britain the government has made a direct policy decision to ration care and inadequately fund capital expenditures in the health care area.

We point out these national health care expenditure figures for other countries to show that the increases in health care expenditures to assure the improved health of the nation are not unique to the United States. We believe that increased resources dedicated to health care is a reflection of a maturing and humane society that places increased emphasis on the protection of its vulnerable population, including the ill and injured.

Inflation and Aging Factors

Health care costs are also not immune to outside market forces. A significant percentage of health care cost increases is attributable directly to the severe inflation that has beset our economy. As a matter of fact, the element contributing the most to the growth in expenditures for health care from the period 1971 to 1981 has been the general inflation affecting the economy. According to an article published in the March 1983 issue of HCFA's Health Care Financing Review, general inflation "accounted for approximately 57% of the increase in total systems costs (personal health care costs) for the period 1971 to 1981." In addition, approximately 8% of the growth in expenditures is specifically attributable to the aggregate population growth over that period of time.

An additional reason for increased health care expenditures is the aging of our population. Health care expenditures and the federal responsibility for health care coverage through Medicare will increase over time as the population and elderly population in particular increases. Between 1983 and 2025, the total population is projected to grow by almost 30 percent, with the elderly population doubling to a total of 58 million or 19.4 percent of the total population. Among the elderly, the group over age 75 will also experience substantial growth: 40 percent of the elderly are now older than age 75, and this figure will increase to 45 percent in 2025; and the over age 85 group will triple from the current 2.5 million people to 7.6 million people in 2025. This substantial increase in the elderly population is particularly important as the elderly have historically utilized a greater proportion of health care resources.

In 1978, the average per capita expenditure for health care by Medicare-eligible individuals was $2,026. The significance of this figure is illustrated by the fact that average per capita spending for individuals between the ages of 19 and 64 totalled $764, and for individuals under age 19 the figure was $286. The statistics also indicate that individuals over the age of 65 are more likely to be hospitalized than those under that age; they use more hospital days per hospitalization; and they visit their physician and other health care practitioners more frequently. The importance of these figures is clear: as the population ages, demands for health care services correspondingly increase and the total cost for providing those services increase.

The AMA recognizes that health care services should be examined for their cost-effectiveness. We have been taking positive actions to review the delivery of health care services and to eliminate those health care costs that are inappropriate and are not benefiting the public. (Attached to this statement is an appendix indicating AMA activities to promote the cost-effective delivery of all health care services.)

AMA's Call for Voluntary Physician Fee Freeze

Last month, the American Medical Association sent a letter to every physician in the country urging each to voluntarily freeze his or her fees for a one-year period and to continue to take into account the financial circumstances of each patient--especially the unemployed, the uninsured, and those under Medicare--and to accept reduced fees when warranted. In a November 1, 1983, letter to all members of the House of Representatives, the AMA has pledged to ask physicians to refrain from passing on additional costs to their elderly patients and to urge all physicians to be considerate of the needs of their patients and to avoid increasing the financial burdens of their patients.

In calling for an across-the-board voluntary freeze of physician fees, the AMA is asking physicians to contribute to a resolution of the economic problems facing our health care system. While physicians services account for only 19% of health expenditures, physicians are now taking a positive step to arrest this trend through the voluntary one year freeze in their fees. With the overall economy as a whole in far better shape today than it was even one year ago and with inflation no longer continuing to grow annually in double digits, the AMA believes that a vast majority of physicians will heed the call to voluntarily freeze their fees.

The voluntary freeze proposed by the AMA applies to all physicians and includes charges to all physicians' patients including those that are covered by Medicare. We believe that this step will be especially helpful in easing the current deficit problems facing the federal government, as the action taken by the AMA is in line with a one-year freeze of Medicare payments to physicians as proposed by the President in his budgetand as provided in various legislative proosals in both Houses of Congress.

AMA Consumer Choice Principles

The evolution of our system of payment for health care has seen workplace-based health insurance emerging as the primary means by which most Americans pay for health care services they receive. The nearly universal coverage of medical expenses by health insurance or Government health programs has insulated most Americans from consideration of the cost of medical services. Many economists have said that this is partly responsible for the continuing rise in medical care costs.

Typical government responses to this situation have been to impose limits on the supply of medical services such as through the ill-fated health planning program. It has been AMA policy that demand for services should also be addressed. Thus competition and individual choice should be enhanced as alternatives to regulation.

To help assess and guide federal legislative proposals impacting upon the nation's health insurance system, the AMA has developed the following principles. These principles should be considered as a whole. They spell out a policy for greater individual choice and for incentives for prudent behavior by individuals. While the principles may singly state appropriate policy, it is intended that all principles be considered in reviewing consumer choice/competition legislation.

1. Employment-Based Health Insurance. The growth of employment-based group health insurance for employees and their families should continue to be encouraged through tax incentives.

2. Adequate Benefits. Each health insurance plan offered to employees should contain adequate benefits, including catastrophic coverage. Plans which do not have adequate benefits should not qualify for tax deduction as a business expense for the employer.

3. Multiple Choice of Plans. Health insurance plan options, with varying levels of coinsurance and deductibles, should be available to employees; accordingly employers, through tax incentives, should be encouraged (but not required) to offer employees a choice of several health insurance plans. Multiple options will better meet individual and family needs and encourage greater individual responsibility in utilization of medical care services.

4. Equal Contributions. Equal employer contributions should be made for health benefit plans, regardless of the plan selected by the employee.

5. Limitation on Tax Deductibility of Excessive Health Insurance Premium. A limit should be placed on the amount of health insurance premiums paid by an employer that would be tax exempt income to the employee, as with life insurance. This amount should be high enough to provide for adequate benefits and should be adjusted for inflation. In order to discourage over-insurance and "first-dollar coverage" which can cause increased demand for care, amounts paid by the employer in excess of the limit would be taxable income to employees.

6. Rebate to Employees. In order to stimulate prudent selection of health insurance by employees, employees may receive non-taxable rebates when choosing an insurance policy where the premium cost is less than the amount of the employer contribution.

7. Quality of Care. Employer health insurance plans should assure employees the free choice of sources of medical care services. Services should be of high quality. Plans should provide comparable benefits for treatment of physical and mental illness.

CONCLUSION

Mr. Chairman, the AMA urges this Committee and Congress to act to help assure access to and the continued high level of quality care provided by our health care system. We believe that the great advances in the American people's health status has occurred because this country has devoted necessary resources to the health care sector and has kept improper government intrusion into the medical marketplace to a minimum. We believe this policy should continue. We also believe that great strides can be made by encouraging the American public to prevent illness through adoption of healthier lifestyles such as improved diets, reduced smoking and exercise. The federal government can play a valuable role in encouraging such activity.

America's physicians stand ready to cooperate in our nation's continuing commitment to assure the highest possible level of health care to all Americans. We urge you to keep in mind, while expenditures for health care have greatly increased over the past 30 years, the nation and its economy as a whole has received significant benefits from these expenditures. These benefits relate to improved health status, longer life expectancy, and improved quality of life. Productivity also increases when absenteeism from illness is reduced and when chronic conditions can be controlled with workers continuing in their jobs.

It should also be remembered that a significant reduction in health care costs could have severe economic effects through decreased employment and the spin-off spending generated by health care income.

For example, since the federal government's new hospital reimbursement system for Medicare went into effect, there have been reports of hospitals initiating significant lay-offs of personnel causing great concern within their communities.

Mr. Chairman, at this time I would be pleased to respond to any questions the Committee may have.

COST-EFFECTIVENESS ACTIVITIES OF THE AMERICAN MEDICAL ASSOCIATION

National Commission on the Cost of Medical Care

The American Medical Association has taken an active role in issues relating to the cost of health care. The AMA was instrumental in the development and operation of the National Commission on the Cost of Medical Care, and has been working to implement recommendations from this Commission relating to strengthening price consciousness, private sector cost containment initiatives, working through the regulatory process, cost containment measures within medical practice, issues relating to supply and distribution of health care providers, research guidelines, and consumer and patient information. An important element of this Commission's report emphasized the importance of changing incentives within the health care delivery system to enhance competition. The 48 recommendations of the Commission on the Cost of Medical Care, issued in 1978, have served as a starting point for AMA activity related to cost-effectiveness.

Cost-Effectiveness Publications

For the past four years, the AMA has published an annual Cost Effectiveness Plan. The 1984 Plan documents the Association's on-going efforts to stem inappropriate growth of medical care costs. This Plan details numerous activities of the AMA to meet its commitments concerning limiting health care costs that are found to be inappropriate.

The American Medical Association fully recognizes that an important element in the growth of cost effectiveness activities is the publication of information about on-going efforts to deliver cost effective health care. To this end, the AMA is in its third year of publishing the AMA Cost Effectiveness Bulletin. This Bulletin is designed to provide cost effectiveness information to state medical associations, metropolitan and county medical societies, and national medical specialty societies. In addition, this Bulletin is generally available to hospitals, hospital associations, and other interested parties. The Bulletin publicizes information on AMA cost effectiveness activities and also publishes information related to the activities of other organized groups working to this end.

Cost-Effectiveness Network

One of the more promising activities that the AMA is involved in concerning cost effectiveness is the recently formulated cost effectiveness network. This network is sponsored by the AMA in cooperation with the American Hospital Association and the Federation of American Hospitals. It is aimed at involving hospital medical staff and administrators in collaborative cost effectiveness activities. The program consists of more than 85 hospitals throughout the country that will take part in experiments to evaluate a variety of cost effectiveness projects.

The first project implemented within this network was a protocol for holding economic grand rounds. (An implementation guide for economic grand rounds has been published and is generally available.) The purpose of this program was to enhance physician awareness of the cost of the services they order by use of the grand rounds teaching forum. This program had essentially four operational goals:

- to encourage practicing physicians to reflect on their practice patterns in the context of cost effectiveness issues;
- to reinforce clinical behavior which is directed toward the cost effective delivery of high quality medical care;
- to change physician behavior where appropriate to reflect more cost effective delivery of high quality care;
- to stimulate additional subsequent activities geared to foster the cost effective delivery of medical care.

As this program and other programs developed through the cost effectiveness network prove beneficial, it is hoped that similar programs can be launched in other hospitals and that a major impact will be felt throughout the health care delivery system. A new program that is now being analyzed through the cost effectiveness network is a study designed to improve the efficiency of the utilization of respiratory care services.

Health Care Coalitions

The AMA has recognized the fact that medicine by itself cannot act to hold down rising health care costs. For this reason, the AMA started working with state and county medical societies in 1979 in the development of community-based health care coalitions. These coalitions work to bring together physicians, business and labor representatives, hospital management, and insurors to provide local forums to seek ways to contain costs while maintaining accessibility and high standards of heath care.

Health care coalitions have had success in such diverse activities as case management and utilization review, expanding physician and employer knowledge about employee limitations in particular work places, redesigning corporate benefits to encourage more cost effective ways to use the health care delivery system, increasing opportunities to develop the most cost effective and equitable forms of provider payments, drafting and supporting legislation to reform medical liability laws, developing health education programs in the workplace, collecting and analyzing data on the utilization of services, and community health planning.

Conferences on Costs

The AMA has undertaken other activities to emphasize the importance of cost effectiveness. In 1982, the AMA cosponsored the National Conference on Utilization of Health Services with the American Hospital Association and the Blue Cross and Blue Shield Associations. This program focused on improving the efficient use of health services through early discharge programs, alternatives to inpatient care, and effective utilization review. Because of the success of this conference, the AMA has expanded its program on utilization of health services. The AMA also sponsors an annual conference, the National Medical Specialty Society Cost Effectiveness Conference, to aid medical specialty societies in the development of cost effectiveness projects that are geared to their own memberships.

Medical Education and Practice

The groundwork for cost effective medical practice must begin in medical school. To this end, a recommendation from the National Commission on the Cost of Medical Care was that medical, dental and osteopathic schools should expose students to the economics of the care they deliver. Since this recommendation was adopted by the AMA House of Delegates in 1978, most medical schools have integrated cost containment as an element of medical education. As of 1981, the subject of cost containment was taught in 93 of the 124 United States medical schools, and the issue was taught in almost every state.

In addition to stressing the value of cost effectiveness in medical education, the AMA is also stressing the value of prevention in all aspects of medical care as a means to achieve cost effective health care delivery in this country. Aside from organized activities geared toward curtailing health care costs, the single most important means by which American physicians work to hold the line on health care costs is in the development of a physician/patient relationship. Through this relationship, physicians work to promote healthier life styles and to educate their patients to prevent disease and injury from occurring. Physicians have been leaders in anti-smoking campaigns and in educating the public on issues such as moderation in the use of alcohol, the use of child passenger restraints in automobiles, and drug abuse.

Health Policy Agenda

The American Medical Association realizes that Congress needs assistance from the public in making any future determinations on how health care services should be delivered in this country in the future. To this end, the American Medical Association has taken the first step by initiating a project to create a future health policy agenda for the American people. This project is designed to develop a philosophical and conceptual framework as the basis for specific action plans and proposals that are to be responsive to the particular social, economic, scientific, educational and political circumstances facing health care decisions. To develop a series of policy principles and action plans, six work groups have been organized to develop policy principles and action plans in the following areas: medical science; health professions education; health resources; health care delivery mechanisms; evaluation, assessment and control; and payment for health care services. The AMA expects that the Health Policy Agenda project will look to the cost of providing health care services.

The first phase of this project, the development of principles, is now nearing completion, and the work groups are now in the process of identifying issues as the next step to developing action plans to carry out the principles. This activity involves approximately 1[illegible]0 organizations including representatives of medicine, government, nursing, labor, business, the hospital industry, the public, and health care insurors. By this broadbased organizational body, we hope to be able to present Congress with viable principles and working programs for the development of a future health policy agenda that will assure the availability of high quality health care services for the American people.

Senator JEPSEN. Thank you.
Mrs. Suther.

STATEMENT OF MARY SUTHER, CHIEF EXECUTIVE OFFICER, VISITING NURSE ASSOCIATION OF DALLAS, TX, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Mrs. SUTHER. Thank you, Mr. Chairman. I tried to alter my testimony summary so I don't repeat anything that's previously been said.

I am Mary Suther. I am the chief executive officer of the Visiting Nurse Association of Dallas, the second largest home care agency in this country and the largest home hospice program in this country. We do serve a caseload of over 4,000 persons a day in their homes with the use of paid staff as well as over 3,000 volunteers which we think does decrease health care costs.

I also serve on the Government Affairs Committee of the National Association for Home Care, the Nation's largest professional association representing home care, home health, hospice, and homemaker/home health aide providers, and it's in that capacity that I will testify today.

This organization is not only interested in testifying as to this difficult matter, but we also have an interest as an employer because we too are employers and we are 80-percent labor-intensive and we, too, are interested in the escalation of health care costs as it relates to the cost of our product.

On behalf of these organizations I want to commend you for holding this hearing to focus on how we can contain escalating health care costs. The thrust of my testimony will be on the need to increase use of home care and other noninstitutional care to help contain both governmental and private business health care costs.

The preceding witnesses have detailed the rising costs of health care, but let me briefly cite some key figures. The 82-percent increase in hospital costs, as identified by CBO, and Government funding of medical care has been focused on institutional care. In fiscal year 1982, 95 percent of medicare part 3, a total of $33.3 billion expenditure, has been on inpatient hospital care, and only 3.5 percent for home care. Under medicaid, in fiscal year 1982, over 30 percent of the $33 billion expenditure went to semiskilled nursing facilities and extended care facilities, 26 percent inpatient hospital care and only 1.7 percent to home care.

As many of the preceding witnesses have testified, the home care industry is an employer and in our business alone—and I thought about this while I was sitting back there and it's a rough estimate—but $80 of every patient's bill from home care is also health care costs and sometimes we, as health care professionals, neglect to include our own health care costs and what that does to increase the cost of our own product.

Some have talked about the cost of health care in terms of the direct costs of health care on American business, but no one has alluded to—I believe one of the preceding witnesses today alluded to the opportunity costs, and in our business, the opportunity costs of a fractured wrist of a nurse is $36,000.

The question is, What do we do about this? Let us look at the private sector first. Our association believes that our Nation has had a dependence on institutional care for too many years. However, only since the Second World War, and business and labor are just now realizing the need to institute new programs emphasizing prehospitalization screening, utilization review and use of home care and other ambulatory care services. Business management is concerned about the cost of health care in terms of accelerating expenditures and labor increasingly is faced with contract negotiations where they must choose between wages and benefits, often due to the pressure of health benefit costs on employers for current employees and retirees.

The awareness is all around us. The U.S. Chamber of Commerce reports 150 employer coalitions to contain health care costs. The consulting firm of William Mercer found in a recent survey of 1,420 companies that 42 percent of the respondents with 10,000 employees or more have plans to develop health care management strategies.

The Midwest Business Group on Health in March 1984 found in a survey of 64 companies representing over 1 million employees in an 8-State area: 52 companies have implemented extended care facility benefits, 10 of these with no requirement for prior hospital stay; 49 have implemented or planned home care; 18 more are considering it; 71 percent have expanded outpatient surgery benefits and 38 percent implemented greater reimbursement than available as an inpatient; 16 have or will be paying for birthing centers, a relatively new concept; 35 others have interest. Incidentally, I have had some experience in that in Atlanta, GA, and there was a tremendous decrease in cost of a combination of the use of birthing centers and home health care.

Hospice care has already been implemented by about 25 percent of those responding; and nearly half expressed interests.

Both the Blue Cross/Blue Shield Association of America and the Health Insurance Association of America have reported an increased trend in the addition of home care and hospice benefits to group health plans.

The AFL–CIO and the National Governors' Conference both recently held special conferences on health care cost containment strategy. And the AFL–CIO Service Employees International Union, and other labor groups have contacted the National Association for Home Care to explore use of home care to reduce health care costs.

And State governments are encouraging this trend. A March 1984 report by the intergovernmental health policy project at George Washington University found 15 States have laws which require insurers to either provide or make available private health insurance benefits for home health care services.

Hospitals themselves are even realizing the need to utilize noninstitutional services. A 1983 survey of 149 hospital administrators found that 74 percent of the hospitals offer alternative services and 15 percent plan to do so. More specific to home care, 25 percent of the hospitals provide home care and 33 percent plan to do so by July 1984. And in the medicare program there has been a boom in hospital and skilled nursing facility-based home health care agencies. Hospital-based agencies have grown from 319 in 1978 to 566 at the end of 1983.

Skilled nursing facility-based agencies have grown from 8 in 1978 to 129 at the end of 1983.

Incidentally, a proliferation of home health agencies increases costs in many instances, primarily due to the fact that when patients are served in their home or their place of residence, the more agencies there are, the further the patients to come, the greater the geographic distance between the patients, thus an increase in cost for the care because transportation costs are much of the costs of the delivery of home care.

Let's look specifically at some cost-savings results related to home care and other noninstitutional services. Here are a few examples.

The American Association for Respiratory Therapy issued a report in February 1984 finding the average cost of care for ventilator-dependent persons to be $270,830 a year per person in a hospital compared to $21,192 per person per year at home.

Blue Cross/Blue Shield of Maryland has reported a savings of $1.2 million in 1982 from its Coordinated Home Care Program, largely by reducing the average subscriber's inpatient-day stays by 8.9 days. Since 1973, the Blue Cross program has reported a net savings of $6.3 million for the program.

Aetna Life and Casualty has reported a $78,000 per case savings from its Individual Care Management Program by using home care for victims of catastrophic accidents.

At least a dozen Blue Cross and Blue Shield plans now offer programs to encourage early maternity discharges to home care. Blue Cross estimates that if only one-half day were cut from the average 3-day normal delivery stay there would be a $40 to $50 million annual savings in hospital costs.

In addition to these and other studies, I can cite numerous case examples from my own agency where we have saved money while providing quality care either by facilitating early hospital or nursing home discharges or by postponing or avoiding entry of clients to a hospital or intensive care facilities or nursing home, or preventing readmission to hospitals. The National Association for Home Care can cite countless examples nationwide.

In addition to the delivery of care in our agency, as I said, many of the home care agencies do provide volunteer services that account for a large number of services provided.

As I noted earlier, hospitals themselves realize the trend and the necessity of utilizing home care. They also realize that under the new medicare DRG system the prudent use of home care can allow them under many diagnoses to provide a safe and early discharge of patients and often give them a profit margin on specific DRG's.

As an aside, I must sympathize with the hospital industry in that now they have 465 product lines to manage and we as health care providers have not been known as product managers in the past and have very little experience in doing so, and it's a shame that our friends from the automotive industry aren't still here—they have far fewer product lines to manage in their national corporate entities than do hospitals with their 465 product lines that they now have to manage. Of course, the people that did the research on DRG's had no experience in product line costing either.

If only the Federal Government had a similar view of home care as a cost containment measure as private industry. We implore you as leaders of Congress and those business leaders here to urge the current administration to take a more reasoned view in this area.

We have approached the Health Care Financing Administration to help rectify some current inconsistencies in their fiscal intermediaries' application of the "intermittent care," "homebound," and "skilled nursing" criteria. I will not belabor you with these technicalities. Suffice it to say that Health Care Financing Administration has not been responsive to our requests to stabilize the current home care benefit.

The big problem with this is that patients being discharged from hospitals earlier now need high technology services, and while there's been no change in the medicare statutes nor changes in the regulations, interpretation of these regulations denies home care under the medicare benefit and the medicaid benefit to many beneficiaries that now need this service in a greater way than they have in the past.

We have not advocated the expansion of the number of home care agencies, though there is a strong evidence to expand it for cost-saving purposes to respiratory care, nutritional care, and pediatric home care. Instead, we have asked HCFA to rationally administer the current benefits so that they will complement the DRG system and our overall health care system. Under the DRG's, a failure to have a rational and adequate home care benefit will only result in more hospital readmissions—something which will increase hospital costs and defeat the cost savings goal of DRG's.

The response that we have received from HCFA is that it doesn't make sense costwise. HCFA asserts that the medicare home health benefit is the fastest growing portion of the medicare budget and, as such, must be limited. They take this view even though home health represents only 3.5 percent of the overall medicare budget and their own data shows only a 2.5-percent rate of overutilization. They refuse to recognize that the growth in home care has been facilitated by the growth in the elderly population, the growth in the number of home health agencies into previously under or unserved areas, people's preference for home care over institutional care and the growth of technology which now enables more procedures to be performed at home that previously were exclusively done in institutions. Furthermore, the Government never has attempted to quantify the cost of institutional care without home care.

In addition to not recognizing the cost-effective benefits of a rationally designed home care benefit, the Government has failed in several other ways. First, in devising the DRG system they did no analysis of the potential impact on home care providers, beneficiaries, and other parts of the health care system. This analysis will be done ex post facto, if at all. We believe it is ill-advised to think that by tinkering with one part of the system—that is, hospital inpatient services, physician services under medicare—if you tinker with one part of the system, you will make a difference without dealing simultaneously with the rest of the system. And I think other people have mentioned this in their testimony today.

Personally, I think that we have failed to utilize the engineering approaches and the systems approach to the development of health care systems in the country. We probably need to start from scratch instead of trying to redesign what we have.

The Government also has failed to assess the impact of its excessive regulatory and paperwork burden on health care providers. Despite alleged efforts to reduce paperwork, many regulations are promulgated without a valid and reliable cost impact assessment, as witnessed by the recent ODR phaseout regulations, the final hospice regulations, which incidentally will make care to rural and small communities virtually impossible due to the effect of having a small number of clients. Actuarially, it's impossible to provide hospice under the regulations in the rural and small communities. DRG regulations themselves also reflect that.

My agency and others have done studies which indicate that the opportunity cost for completing unnecessary, duplicative paperwork required by medicare and other governmental programs—and this is not just for medicare beneficiaries. We are required to provide this to all home care patients, whether third party payers are governmental or not. This adds 30 percent to the cost to every unit of service that we provide, and I've done studies and reported these studies many times to the Senate Finance Committee's Subcommittee on Aging and other bodies in this Senate.

By opportunity costs, of course, I mean the value of revenue or service that we forego as a result of having to comply with excessive Government regulations.

We need the same leadership on this issue in Congress that we've had in the private business, labor, and health insurance industry. We no longer can continue our institutional care bias. It costs too much money and, in acute care situations, doesn't necessarily provide better quality care. We hope you will join us in our efforts to open the eyes of Congress and the administration to the need to reverse this ill-conceived policy.

Of course, we do recognize the fact that institutions are necessary and appropriate in many instances and we would by no means say that home care should take the place of institutional care.

I'd like to respond to one question that you asked earlier about the analysis of HMO users. I have personally done some analysis of our own HMO users and find that there are two cohorts. One cohort is the sicker employees and the ones that tend to have more health care problems. The other cohort is the prevention-oriented cohort. We found two separate cohorts. And also, the mobile employees, the ones who do not already have a family care physician when they come to work for us.

Thank you very much.

[The prepared statement of Mrs. Suther follows:]

PREPARED STATEMENT OF MARY SUTHER

Mr. Chairman and Members of the Committee:

My name is Mary Suther. I am the Chief Executive Officer of the Visiting Nurse Association of Dallas. I also serve on the Government Affairs Committee of the National Association for Home Care (NAHC) - the nation's largest professional association representing home health, hospice and homemaker/home health aide providers.

On behalf of these organizations I want to commend you for holding this hearing to focus on how we can contain escalating health care costs. The thrust of my testimony will be on the need to increase use of home care and other non-institutional care to help contain both governmental and private business health care costs.

The preceeding witnesses have detailed the rising costs of health care, but let me briefly cite some key figures.

(1) The nation's health care expenditures have grown by an annual average rate of 13.2 percent from 1971 - 1981 and are projected to grow by 11-12 percent from 1981 - 1990. (source: Health Care Financing Review, March 1983)

(2) Per capita health care expenditures have grown from $394 in 1971 to $1,225 in 1981 - and are projected to increase to nearly $3,000 by 1990. (source: Health Care Financing Review, March 1983)

(3) On February 21, 1983, the Congressional Budget Office (CBO) estimated that 10.8 percent (or 82 percent) of the total 13.2 percent annual growth in health care costs is attributable to hospital costs.

(4) CBO and others project that the Medicare trust fund will be bankrupt by 1988 - 1990 if significant statutory changes are not made in the fund's income and expenditure policies.

(5) Government funding of health care through Medicare and Medicaid has been focused on institutional care. In fiscal year 1982, 95 percent ($32.7 billion) of Medicare Part A's total $34.3 billion expenditures went to inpatient hospital care and only 3.5 percent ($1.2 billion) to home health care. Under Medicaid in FY 1982, over 30 percent ($9.2 billion) of all $30 billion in expenditures went to SNFs and ICFs, 26 percent ($7.8 billion) to inpatient hospital care and only 1.7 percent ($496 million) to home health.

(6) In the private sector, the U.S. Chamber of Commerce recently reported that the average employer spends $2,228 a year per employee on health care coss or 11.5 percent of payroll. Health benefits are about 25 prcent of all employee benefits and employee benefits rose 183 percent between 1971 - 1982 while wages rose only at 139 percent.

The question is what to do about this.

Let us look at the private sector first. Our Association believes that our nation has had a dependence on institutional care for too many years. And business and labor are just now realizing the need to institute new programs emphasizing pre-hospitalization screening, utilization review and use of home care and other ambulatory care services. Business management is concerned about the cost of health care in terms of accelerating expenditures and labor increasingly is faced with contract negotiations where they must chose between wages and benefits, often due to the pressure of health benefit costs on employers for current employees and retirees.

The awareness is all around us:

(1) The U.S. Chamber of Commerce reports 150 employer coalitions to contain health care costs.

(2) The consulting firm of William M. Mercer, Inc. found in a recent survey of 1,420 companies that 42 percent of the respondents with 10,000 employees or more have plans to develop health care management strategies.

(3) The Midwest Business Group on Health in March 1984 found in a survey of sixty-four companies representing over 1 million employees in an 8 state area:

- 52 companies have implemented extended care facility benefits, 10 of these with no requirement for prior hospital stay.
- 49 have implemented or planned home care; 18 are considering it.
- 72% have expanded out-patient surgery benefits and 38% implemented greater reimbursement than available as an in-patient.
- 16 have or will be paying for birthing centers, a relatively new concept; 35 have interest.
- Hospice care has already been implemented by about 25% of those responding; nearly half expressed interest.

(4) Both the Blue Cross/Blue Shield Association of America and the Health Insurance of Association of America have reported an increased trend in the addition of home care and hospice benefits to group health plans.

(5) The AFL-CIO and the National Governor's Conference both recently held special conferences on health care cost containment strategy. And the AFL-CIO, Service Employees International Union, and other labor groups have contacted NAHC to explore use of home care to reduce health care costs.

And State governments are encouraging this trend. A March 1984 report by the Intergovermental Health Policy Project (at George Washington University) found 15 states have laws which require insurers to either provide or make available private health insurance benefits for home health care services.

Hospitals themselves are even realizing the need to utilize non-institutional services. A 1983 survey of 149 hospital administrators (by National Research Corp., Lincoln, Nebraska) found that 74 percent of the hospitals offer "alternative" (non-inpatient) services and 15 percent plan to. More specific to home care, 25 percent of the hospitals provide home care and 33 percent plan to by July 1984. And in the Medicare program there has been a boom in hospital and SNF-based home care agencies. Hospital-based agencies have grown from 319 in 1978 to 566 at the end of 1983; SNF-based have grown from 8 in 1978 to 129 at the end of 1983.

But let's look specifically at some cost-savings results related to home care and other non-institutional services. Here are a few examples:

(1) The American Association for Respiratory Therapy isued a report in February 1984 finding the average cost of care for ventilator-dependent persons to be $270,830 a year per person in a hospital compared to $21,192 per person per year at home.

(2) Blue Cross/Blue Shield of Maryland has reported a savings of $1.2 million in 1982 from its Coordinated Home Care Program, largely by reducing the average subsciber's inpatient day stays by 8.9 days. Since 1973 the Blue Cross program has reported a net savings of $6.3 million for the program.

(3) Aetna Life and Casualty has reported a $78,000 per case savings from its Individual Care Management Program by using home care for victims of catastrophic accidents.

(4) At least a dozen Blue Cross and Blue Shield Plans now offer programs to encourage early maternity discharges to home care. Blue Cross estimates that if only one-half day were cut from the average 3-day normal delivery stay there would be a $40 - $50 million annual savings in hospital costs.

In addition to these and other studies, I can cite numerous case examples from my own agency where we have saved money while providing quality care either by facilitating early hospital/nursing home discharges or by postponing or avoiding entry of clients to a hospital, ICF or nursing home. And NAHC can cite you countless examples nationwide.

As I noted earlier, hospitals themselves realize the trend and the necessity of utilizing home care. They also realize that under the new Medicare DRG system the prudent use of home care can allow them under many diagnoses to provide a safe and early discharge of patients and often give them a profit margin on specific DRGs.

If only the Federal government had a similar view of home care as a cost containment measure. We implore you as leaders of Congress and those business leaders here to urge the current Administration to take a more reasoned view in this area.

We have approached the Health Care Financing Administration (HCFA) to help rectify some current inconsistencies in their fiscal interemediaries' application of the "intermittent care", "homebound", and "skilled nursing" criteria. I will not belabor you with technicalities. Suffice it to say, HCFA has not been responsive to our requests to stabilize the current home care benefit.

We have not advocated the expansion of home care - though there is strong evidence to expand it for cost-savings purposes to respiratory care, nutritional care, and pediatric home care. Instead we have asked HCFA to rationaly administer the current benefit so that it will complement the DRG system and our overall health care system. Under the DRGs, a failure to have a rational and adequate home care benefit will only result in more hospital readmissions — something which will increase hospital costs and defeat the cost savings goal of DRGs.

The response we have received is that it doesn't make sense cost-wise. HCFA asserts that the Medicare home health benefit is the fastest growing portion of the Medicare budget and, as such, must be limited. They take this view even though home health represents only 3.5 percent of the overall Medicare budget and their own data shows only a 2.5 percent rate of overutilzation. They refuse to recognize that the growth in home care has been facilitated by the growth in the elderly population, the growth in the number of home health agencies into previously under or unserved areas, people's preference for home care over institutional care and the growth of technology which now enables more procedures to be performed at home that previously were exclusively done in institutions. Furthermore, the government never has attempted to quantify the cost of institutional care without home care.

In addition to not recognizing the cost-effective benefits of a rationally-designed home care benefit, the government has failed in several other ways. First, in devising the DRG system they did no analysis of the potential impact on home care providers, beneficiaries and other parts of the health care system. This analysis will be done ex-post-facto, if at all. We believe it is ill-advised to think that by tinkering with one part of the system (i.e., hospital inpatient services under Medicare) you will make a difference without dealing simultaneously with the rest of the system — SNFs, ICFs, home care, HMOs, and physicians.

The government also has failed to assess the impact of its excessive regulatory and paperwork burden on health care providers. Despite alleged efforts to reduce paperwork, many regulations are promulgated without a valid and reliable cost impact assessment -- as witnessed by the recent ODR phaseout regulations, the final hospice regulations, and the DRG regulations themselves. My agency and others have done studies which indicate that the "opportunity cost" for completing various forms and other regulatory requirements is 30 percent of our costs. By "opportunity cost" I mean the value of revenue or service we forgo as a result of having to comply with excessive government regulations.

We need the same leadership on this issue in Congress that we've had in the private business, labor and health insurance industry. We no longer can continue our institutional care bias. It costs too much money and, in acute care situations, doesn't necessarily provide better quality care. We hope you'll join us in our efforts to open the eyes of Congress and the Administration to the need to reverse this ill-conceived policy.

Thank you.

Senator **Jepsen**. Thank you.

Dr. Nelson, it's been suggested that while there's presently a shortage of physicians in many parts of the country, within a few years we may have a tremendous oversupply of physicians.

What does the American Medical Association see happening in this area and are we going to have an oversupply of doctors in the not too distant future, do you think?

Dr. **Nelson**. There is no question that there is a rapid increasingly supply of physicians. That can be counted fairly accurately. The problems come in accurately projecting what the needs will be. There are some full-fledged specialties now with busy physicians doing procedures that weren't even contemplated 20 years ago. Who could have foreseen the amount of coronary artery surgery that's being done by thoracic surgeons, for instance, today? The imagary techniques in radiology, who could have foreseen that?

The difficulty comes in understanding what the needs will be. The American Medical Association has a position that market forces will eventually deal with the problem of increasing physician supply, if indeed there is an oversupply, and already we see some validation of that concept. Last year, for the first time, there was a decrease in the number of entering first-year medical students, for instance.

Senator **Jepsen**. Mr. Owen, many hospitals in Iowa and many other parts of the country are experiencing significant declines in the patient population. It's not unusual to see a hospital that has 60 or 50 percent occupancy.

What are hospitals doing about this decline and are we going to see hospitals start closing their doors or wings of the hospital? Of course, it's obvious that in my constituency I'm deeply concerned about this and its primarily rural nature in the rural areas where this problem seems to be particularly serious. What is the association doing or planning to do about this?

Mr. **Owen**. You are right, Mr. Chairman, there is a drop in occupancy and it's occurring across the country. I think what needs to be done is one of the things that's coming out of your leadership and Senator Grassley's, and that is some allowing of swing beds which allows the hospital that has the drop in occupancy to use those beds for long-term care patients.

We have a serious shortage of long-term care beds and, as Dr. Nelson pointed out, if we look and see what's going to happen a few years from now with the aged population, we haven't even addressed the problem of how we are going to take care of many of these people in skilled nursing facilities and long-term care units.

We've had some crazy regulations and rules that says that the hospital can't use its beds for long-term care unless there's some legislation that allows for swing. It doesn't make any sense that a physician, medical staff, nurses who take care of patients with brain surgery and open heart surgery, can't take care of a patient who needs some skilled nursing care. It just doesn't make any sense.

So I feel very strongly that those empty beds that are out there in Iowa and other parts of our country could be utilized very effectively in a long-term care situation and I suspect—and I think I'm correct in this—but Iowa has a very large percentage of over-65. I've forgotten where you rank as a State, but it's within the top five States, almost next to Florida. And I suspect that, although we're seeing this drop in occupancy occur right now because of the DRG system and what have you, we will see with the aging and the growth of the population that those beds will be needed again. And to close hospitals down and run out of business doesn't make any sense when they could be used for long-term care and other kinds of health care.

Senator JEPSEN. Thank you, Mr. Owen.

Mrs. Suther, as you may know, I've long been an advocate of increased utilization of home care to contain costs. One of the arguments I run into quite often with the people here in Washington is what I call the woodwork problem. You may call it something different, but what this refers to is the assumption that expanding home care programs will be making services available to people who otherwise would not be utilizing the health care network and so even though the individual cost of home care may be less expensive, the aggregate costs of health care will increase because people will be using the services.

Would you care to comment and take a moment to respond to the so-called woodwork argument?

Mrs. SUTHER. I think it's an invalid argument. Certainly, there would be a few people that might access the system that would not normally access that system, but I think that you're aware that the gatekeepers of home heath service are the physicians and the hospitals and we do not receive referrals unless they are already under medical supervision in home care. We must have physician referral. So the person is already receiving medical services of some kind.

The greatest portion of our referrals come directly from hospitals and these people are already in the health care system. We are not advocating opening the gates totally. Of course, I guess this is one of the things that makes home care a little different in the competitive force because the consumer is not the patient or the end user of the service. The consumer is the go-between or the intermediary because all of the services for home care are controlled by the physician.

Senator JEPSEN. Any comment on that, Dr. Nelson?

Dr. NELSON. Well, first of all, I'm a big fan of the appropriate use of home health services, but it's indisputable that the patient who has been informed of the availability of home health services and who requests of their physician that those services be made available, the physician will comply with the patient's wishes because, after all, that's his job. He's the patient's advocate. He's not the rationer of care. He's the provider of care. And unless there is some component of the care that's harmful to the patient, the patient's physician will accede to their wishes and that's the way it ought to be.

It gets back to the point I made about the demand for care. Patient initiated demand is something we don't pay very much attention to. If a new drug for arthritis hits the late press, I can expect a whole host of phone calls the next day from my patients who want to ask about that. And as we publicize the availability of home health services in a community, we will have more and more people who will ask for that, and it may be totally appropriate. As a matter of fact, perhaps that's where we ought to make our investment. Perhaps society wants the advantages that come with good home health care. I personally do. But I don't think that we can apriori assume that that will decrease their costs.

Mrs. SUTHER. Primarily, only if home care is used in lieu of other services, more costly services, that's the way costs could be decreased, not if it's used in addition to the normal usage pattern.

Mr. OWEN. If I could just comment for a second on that and other things related to it, it seems that in most studies that we have seen that where the patients themselves participates and then has a choice to make, if a third party payer is paying for the patient, he's not so apt to choose what's the most appropriate place to go. If he has the choice between paying the hospital bill or paying for home health care and it's coming out of his pocket or he has some relationship to that, he more than likely will choose home health care because it's less expensive, and he probably should. If, however, somebody else is paying the bill, the chances of him using it are slim.

A good example. I recall in the case in New Jersey where there was a rate review for Blue Cross and I happened to be at the hospital association up there at the time and a union steward in a shop in New Brunswick was talking to me about their Blue Cross coverage for the workers in that particular plant, and in one case one of the workers needed a berium enema. And he said, "If he goes to the doctor and gets that it's going to cost him $50 and he loses a day's work. If he's admitted to a hospital, he will be there 3 days, his work will be paid for, and Blue Cross will pick up the total cost."

Now the shop steward says, "What am I going to say to that worker?" And you know what he would say and probably most of us would say.

So the whole system has been designed to overutilize. I think that's what makes the difference when we look at what is the most appropriate care when people have to make that selection.

Senator JEPSEN. If you could and would give me a one-liner as to your opinion of the national commission studying and developing health care policy in this country that was talked about earlier this morning, Mr. Owen?

Mr. OWEN. I think we would like to see—although we have no strong objection to a commission, we don't think there's going to be a whole lot accomplished by that. We would rather see things left alone for at least a year and see what happens in medicare and see what effect the DRG system has on the rest of the payers, and then after that year is up—because we are seeing some remarkable things happen, and now to change something before we've had a chance to try it out, it seems premature.

Senator JEPSEN. Dr. Nelson.

Dr. NELSON. We would prefer to see that kind of activity which is largely factfinding and advisory done within the private sector and then let our elected Representatives in Congress do their job based on all of the needs.

Senator JEPSEN. Mrs. Suther.

Mrs. SUTHER. Our association hasn't taken a position on it, but personally I feel that that commission probably would not be any more beneficial than some of the others in the past have been, and I also prefer to have on factfinding groups people with pragmatic attitudes toward health care delivery as a business look at this whole problem.

Senator **Jepsen**. Do any of you have a closing statement for the record?

Mr. **Owen**. I'd just like to thank you, Senator, because I think this was a good hearing and it was well done and needed to be done.

Dr. **Nelson**. The AMA went through a very laborious exercise with the Cost Management Commission on Cost of Health Care who published its finding in 1976 or 1977. Many of those findings have subsequently been implemented. Some are yet to be implemented. We would be happy to send you a copy of that.

Senator **Jepsen**. I thank you.

Mrs. **Suther**. I thank you very much for inviting us today.

Senator **Jepsen**. Thank you for coming. Thank you all.

Now we will go to panel 4. The last witness will be the representative of the Health Insurance Association of America [HIAA]. The health insurance industry does not fall into the category of either consumer or provider so it was not included on our earlier panels. It also has a perspective on health care costs different from that of individual businesses. Consequently, it was felt that HIAA, the Health Insurance Association of America, might try to wrap up the hearing and bring it all into perspective.

Mr. James Dorsch.

STATEMENT OF JAMES A. DORSCH, WASHINGTON COUNSEL, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. **Dorsch**. I do appreciate being here and it's a real honor to be the last panel. You have had a very excellent hearing. You've had extensive and exhaustive comments, remarks, facts, and figures from employers, and the consumers, particularly on the extent of the problems caused by the rising cost of health care. I will not try and repeat or replicate that.

I will say, however, that I do not believe they in any way overestimate the problem. It is a real problem and the rising cost of health care is the major concern of the Health Insurance Association of America.

With that, I think I would prefer just to have my full statement entered in the record, if that's all right, give you a very brief summary, and then go on and take questions and see if I can be of help.

The HIAA is pleased that you are raising the issue of the rising cost of health care so soon after the passage of H.R. 1900, the Social Security Amendments of 1983.

The change in payment basis under medicare would probably not have been proposed were it not for persistent, rapid increases in health care costs in recent years.

We have supported prospective pricing for years and we applaud the passage of H.R. 1900 last year. However, these increases and their effects on Government programs are just as applicable to the insurance coverage purchased by employer for their employees, by individuals for themselves, and by the self-insured. As a result, when combined with medicare underpayments, which we call cost shifting, health insurance premiums are increasing annually at rates which range from 15 to 30 percent depending on the size and location of the business. In some cases, even more. These increases are ultimately shared by the employers, employees, and consumers and adversely affect the health of American industry.

We've had solutions for it which emphasize State programs for cost containment based on Federal criteria. We particularly commend the Congress for its recognition of qualified State programs as an alternative method of medicare payment under the Social Security Amendments of 1983. We urge you now to adopt positive incentives to States to develop their own qualified programs for all patients.

One such incentive would be a medicaid reward for those States which enact qualified programs, similar to the reward in present law for States which had hospital cost-containment programs in place on July 1, 1981, but which would provide no reward for any State that put in the program after that date.

We further urge the Congress to take the next step on prospective pricing—that is, to enact legislation extending a hospital prospective pricing system to all payers, not just medicare, to take effect 4 years after the date of enactment in any State which has not enacted a qualified State program of its own. Such legislation would give every State time to enact legislation suitable to its own particular needs and yet guarantees that all of our citizens get the protection they deserve.

What we would like to see, Mr. Chairman, is a level playing field for all third party payers, including medicare and medicaid. When medicare pays less, private payers pay more—in effect, constituting a hidden tax on nongovernment patients which is expected to be $8.8 billion in 1984.

We would like to do more ourselves by way of negotiation with hospitals to contain costs, but individually, the commercial health insurance companies are too economically dispersed to have sufficient leverage to be effective in those negotiations. Collectively, they are prohibited by Federal law.

We would like to change that and specifically request congressional authority to share data and engage in joint cost-containment activities such as negotiating with health providers and the development of physician profiles and patterns of care.

We support, therefore, S. 2051, introduced by Senator Arlen Specter, which would give insurers that authority.

On the other side of the cost-containment coin, Mr. Chairman, the administration has asked Congress to levy a tax on employee health plans as part of its fiscal year 1985 legislative program.

The health insurance industry opposes this proposal as discriminatory, unfair, and one that will do nothing to stop health care cost inflation.

A prospective all-patients system will force cost-saving incentives into the structure of hospital payments and operations and will have many times the impact of the Band-Aid approach of taxing workers' health insurance premiums.

We very much appreciate this opportunity to present our views and I would be very happy to take any questions.

[The prepared statement of Mr. Dorsch follows:]

PREPARED STATEMENT OF JAMES A. DORSCH

My name is James A. Dorsch, Washington Counsel of the Health Insurance Association of America. The HIAA is a trade association of approximately 325 companies which together write over 85% of the country's commercial health insurance. We appear today on their behalf.

We are pleased that you are raising the issue of rising health costs shortly after the passage of H.R. 1900, the Social Security Amendments of 1983.

The recently enacted law serves as a good starting point for discussion of the issues. It changes Medicare's hospital payment for the present retrospective determination of incurred costs to a system of prospectively determined prices. We agree that this change in incentives is highly desirable. In fact, prospective payment may be our last chance for a competitive solution to rising hospital costs. However, the new prospective pricing system applies only to Medicare. Any system that does not apply to all patients will not produce the desired changes in hospital behavior.

The change in payment basis under Medicare would probably not have been proposed were it not for persistent, rapid increases in health care costs in recent years. These increases and their effects on government programs are just as applicable to the insurance coverage purchased by employers for their employees, by individuals for themselves, and by the self-insured. As a result, annual health insurance premiums are currently increasing at rates which range from 15 to 30 depending on the size and location of the business. These increases are ultimately shared by the employers, employees and consumers and adversely affect the health of American industry.

A prospective pricing system which applies only to Medicare will admittedly hold down Medicare outlays, but hospitals could simply shift to other payers. If the change to a prospective system provides the right incentives to hospitals to voluntarily control health care expenses, and we agree that it does, such a change is equally needed by those who are not eligible for Medicare.

The existence of cost shifting has become well-documented since our industry publicly identified the problem a couple of years ago. Cost shifting totalled $5.8 billion in 1982. According to our latest estimates, the cost shift will grow to $8.8 billion in 1984.

As a logical business practice, hospitals recoup reductions in Medicare and Medicaid reimbursement by inflating charges to private patients. Those who are insured faced higher premiums. Those who are not - such as laid-off workers who have lost their insurance - are faced with a ruinous hidden tax exacted at a time when they are least able to pay - a tax on their already sky-rocketing hospital charges. Without government action on an all-payer system, all private patients remain vulnerable to an unprecedented and financially intolerable level of cost shifting.

In theory, prospective payment leads to cost containment because hospitals will work with physicians to voluntarily reduce length of stay and ancillary services. The incentive for such behavorial changes is profit; hospitals will finally be able to get more money for doing less. But hospitals say such changes take time and substantial effort. In practice, hospitals will find it far easier to cost shift than to cost contain.

We support federal legislation that effectively protects private patients from additional cost shifts. Such protection could take the form of a residual prospective payment system for all-payers. While such a system would provide cost containment incentives, it need not produce savings to the private sector in the short-run. Furthermore, an all-payer system would not necessarily require that all-payers initially pay the same price for hospital services. But discounts ought to be justified by savings to the hospital and be available to all hospitals. For example, discounts for prompt payment would be appropriate. Government patients in Maryland are an exception to this principle. While sharing in all costs to the hospital including uncompensated care, they are eligible for an additional allowance in order to stay within the aggregate federal cap required under the Medicare waiver.

I would like to shed some light on arguments against an all-payer system. The Administration says that we private insurers will piggyback on the Medicare DRG prices once we recognize that we are paying too much for hospital care. Mr. Chairman, we already know we are paying too much but we are unable to pay less under a combination of current federal policies that generate cost shifting while prohibiting joint negotiation by insurers. We are caught between the competitive forces in the insurance market and the failures in the non-competitive hospital industry. Current comprehensive benefit contracts with employers would prohibit us from limiting our payments to hospitals to the Medicare rate because hospitals would bill employees for the difference. Employers and employees have made a conscious decision to elect comprehensive medical benefits in 90% of our group business.

If, in the future, an individual insurance company only offered to sell plans which limit benefits to the Medicare DRG rates, employers would again exercise their option in the free market to buy comprehensive benefits from another insurance company. What if the federal government intervened in the competitive health insurance market and prohibited the selling of comprehensive medical benefits; would you then indirectly succeed in controlling hospital costs? No, hospitals would charge patients all that the market would bear above the indemnity amounts. Many hospitals would soon fin their solvency threatened as bad debts amounted.

You may ask whether we negotiate with hospitals to accept less than their charges as full payment. Hospitals have agreed to such requests to voluntarily reduce their revenues only where an employer or insurer has sufficient volume to force acceptance. Some Blue Cross plans so dominate their local areas as to be successful in obtaining such volume discounts. For the vast majority of the country, however, neither the insurance company nor the employer has sufficient local volume to negotiate charges and thereby prevent cost shifting. To drive home the point, the Prudential, which is the single largest private health insurer in the country, has only 4% of the private health insurance market, and that is spread over 50 states. We are too dispersed to negotiate individually and we are prohibited by antitrust laws from negotiating jointly.

Experience validates our frustrations over cost shifting. Experience has also shown that second-opinion surgery, ambulatory benefits and other coverage designed to reduce utilization are successful but alone have limited impact. Finally, experience with State prospective payment systems demonstrates their effectiveness in containing aggregate health care costs.

This is a developing area and no one yet can claim to have all the answers to the questions of a single hospital payment reform system. In fact, two of the oldest and most effective systems, the Maryland and New Jersey programs, operate quite differently. HHS recently granted waivers to New York and Massachusetts, two of the nation's high cost states. In both of these states, all parties with a direct stake in hospital payment change--providers, employers, unions and insurers--actively participated in designing a solution. Both are implementing approaches different from those in Maryland and New Jersey. We believe all of these different approaches will lower costs and produce useful comparisons.

The federal government's past role as a catalyst has helped encourage variety and innovation. We believe this is the prime role for the federal government, and should be continued. We applaud and commend the Congress for its recognition of qualified state programs as an alternative method of Medicare payment under the Social Security Amendments of 1983. We urge you now to adopt positive incentives to States to develop their own qualified programs for all patients.

One such incentive would be a Medicaid reward for those States which enact qualified programs similar to the reward in present law for States which had hospital cost containment programs in place on July 1, 1981. A modest Medicaid reward would be most appropriate for those States which are moving ahead to help solve a national problem—health cost inflation. It would be a fitting way to attack a national problem at the State level without a new Federal bureaucracy. It would be a fitting reward to those States which, by holding down rising health costs, are taking action to hold down the number of citizens forced into Medicaid and other public assistance programs by health care inflation. Such a proposal need not, in fact, should not, require the States to set-up hospital rate setting commissions. It need not, and should not, require any particular type of program, rate-setting, DRG, or otherwise, as long as the State program meets the criteria set forth in the Social Security Amendments of 1983.

We further urge the Congress to take the next step on prospective pricing - to enact legislation extending a hospital prospective pricing system to all payers, not just Medicare, to take effect four years after enactment in any State which has not enacted a qualified State program. Such legislation would give every State time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve. It would also provide a stimulus to those who believe our problems are best solved at the State level to move ahead and get the job done so there will be no need for a Federal all-payer program.

We also recognize that any over-all solution to the problem of rising health costs requires a reconciliation of the vital interests of a number of important segments of our society. Therefore we continue to support the appointment of a Presidential Commission, upon which all of these interests, providers, insurers, employers, and unions, among others, can be represented and which can be charged with the constructive resolution of the conflicts which make this problem so intractable.

Mr. Chairman, the health insurance business shares your strong commitment to cost containment. There is more we would like to do ourselves. Nevertheless, we find that we must struggle under some formidable handicaps. The field on which we compete is strewn with regulatory and economic obstacles that significantly interfere both with our ability to serve our customers and with efforts to improve the efficiency of the health care financing and delivery system as a whole.

Put another way, what would the insurance industry like to do and what are the barriers to their doing it?

Let us first identify these handicaps, all of which are externally imposed upon us. Then we will return to a discussion of each of them. Unlike the noninsured plans with which we compete, we are subject to stringent state regulation. Our product design creativety is also stifled by a range of provider protection laws. Unlike our chief competitors in many instances, we pay state premium taxes and federal income taxes on the earnings on our reserves. In addition, the highly competitive nature of our business and the antitrust laws preclude us from collaborating effectively for cost containment purposes.

If the eficiency of our health care system is ever going to be improved through more meaningful patient participation, we must first make certain that the choices available to consumers are not economically biased because of governmental constraints. When individuals or employers choose a third party payment mechanism, the choice should be among realistic alternatives. This is not fully possible today.

What we would like to see is a "level playing field" for all third party payors, including Medicare and Medicaid. When Medicare pays less, private payors pay more--in effect constituting a hidden tax on non-government patients which is expected to be $8.8 billion in 1984.

This cost shift severely impedes the ability of private payors to compete with government programs under Medicare voucher system such as that proposed by the Administration.

We want Medicare to pay on the same basis as other payors. The provision in the recently-enacted Social Security Amendments providing for Medicare recognition of qualified state hospital payment programs is a major step in the right direction.

Another possibility would be to require Medicare-approved hospitals to allocate equally among all private patients that portion of their budgets not reimbursed by Medicare or Medicaid.

Second, as with the Medicare cost shift, state regulation does not apply evenly to various classes of payors. Employers that self-insure employee welfare benefit plans are exempted from state regulation by the preemption clause in Section 514(c) of ERISA. Such noninsured plans are not subject to the myriad legislative and regulatory requirements imposed upon insured plans. These requirements, which vary considerably from state to state, typically include a wide range of mandated benefits, free choice of provider provisions, and continuation of coverage and conversion options which are often quite costly. Employers may avoid these obligations as well as the necessity of maintaining reserves and paying premium taxes simply by not insuring their plans.

In order to nurture competition in the health care field, we should assure that all competitors are subject to the same rules.

Insurance laws and regulations serve a beneficial purpose in protecting the insured public. However, ERISA now precludes the states from regulating the affairs of noninsured health plans, but at the same time the federal government has failed to regulate these health plans.

It is also a very real impediment to innovative plan design by insurers.

We recommend that Congress require that state taxation and regulation apply equally to all funding mechanisms. We are not proposing a substitution of federal for state regulation. However, our business does support, for example, Section 3605(a)(ii)(I) of S.1541 (the Retirement Income Incentives and Administrative Simplification Act, introduced by Senator Nickles) which would amend ERISA to preempt state mandated benefit laws for insured as well as for non-insured employee benefit plans. This simple change would be a first step along the way to more equitable competition and more rational benefit design.

We would like to set up programs in every state, as we have done in Connecticut, to guarantee the availability of health insurance to all individuals. However, again, ERISA is a major barrier to our seeking state laws setting up these programs. We feel strongly that all competitors in the employee health benefit market should share proportionately in any program losses. However, ERISA preempts state laws to the extent those laws require self-insured plans to participate in these state programs. Thus, self-insured plans are effectively shielded from the economic burden of the guaranteed availability programs, a burden which falls on an ever-decreasing base caused by existing legal barriers to equitable competition. The program could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools and requiring all employee health benefit plan funding mechanisms to participate in such a pool as a condition of income tax deductibility or by otherwise requiring self-insured employers to participate in such programs.

In a similar vein, there are any number of state laws enacted to protect the interests of different classes of providers. These laws often operate to prevent the establishment of preferred provider plans by insurers and stand in the way of negotiations between insurers and providers. They essentially preclude any insurer from restricting in any way any beneficiary's "freedom to choose" any health provider the insured wishes. An interesting experiment is beginning on this subject in California; and we should know before too long whether competition among providers will be enhanced by California's new law allowing an insurer to negotiate with providers. Note, the California law still does not allow more than one insurer to jointly negotiate.

Last, we would like to share data and engage in joint cost containment activities, such as negotiating with health providers, the development of physician profiles and patterns of care, and other such activities. Specifically:

1. Insurers should be authorized jointly to collect, analyze and use information on the quality, cost, or utilization of health care services, including the development of reasonable, or preferred utilization practices as guides for insurance reimbursements to providers. In other words, commercial insurers should be able to join together to assemble data.

2. Insurers should also be empowered collectively to negotiate with health care providers to develop utilization standards. It should further be possible for insurers jointly to contract with review organizations to provide peer review and concurrent hospital review for private patients and to provide data to such organizations.

For that reason the Health Insurance Association strongly supports S. 2051, introduced by Senator Arlen Specter.

Senator Specter's bill will, for the first time, allow insurance companies to cooperate in collecting, sharing and using important health care data to analyze costs and quality. That data, in turn, can be given to consumers and employers, thus helping them make more educated health care decisions. And finally, the bill will give those who pay for hospital care the ability to join together to negotiate for better rates and care without violating federal law.

Most significantly, the bill satisfies two important criteria in the nation's fight to control rising costs: First, it creates competition among hospitals, and second, it is a private sector initiative requiring no taxes, no government intervention and no additional burden to patients, consumers or employers.

Employee Health Tax

On the other side of the cost containment coin, Mr. Chairman, the Administration has asked Congress to levy a tax on employee health plans as part of its F.Y. 1985 legislative program.

The health insurance industry opposes this proposal as discriminatory, unfair, and one that will do nothing to stop health-care-cost inflation, nor will it raise the revenue suggested as labor-management negotiations rearrange the employee benefit package.

Among the arguments against such a tax are a following:

- It penalizes older workers. Elderly groups tend to use health care more frequently than younger, healthier workers. Hence, the cost of health insurance for a group which includes more than the average number of older workers not only will be higher but could discourage many employers from hiring the older worker. Under the Administration porposal, these groups will be adversely affected by a cap, while younger groups with similar coverage may not be taxed.

- It penalizes those in hazardous, high-risk occupations. Some groups, such as iron workers or coal miners, are usually considered a higher "risk," and are typically charged higher health insurane premiums. These groups could be unfairly taxed while other groups with similar coverage--such as clerical workers--would be unaffected.

- It is a form of "double taxation." The Health Insurance Association of America estimates that Medicare and Medicaid payment practices will result in $8.8 billion being shifted to patients covered by private health insurance in 1984 to make up for government underpayments to hospitals. For the government to shift these costs to the private sector and then put a tax on the resulting higher insurance premiums is patently unfair.

- It unfairly affects certain geographic areas. The cost of health care is higher in some areas, such as large metropolitan cities. A single national tax cap does not take geographic differences into account, and thus would particularly penalize those in high-cost areas. Conversely, it would allow the tax-free purchase of much more generous benefit plans by those in low-cost areas.

- It could result in reduced coverage for preventive care services. As employees scramble to reduce their overall premium rates, essential preventive care services such as dental care, vision care, mental health benefits, and alcohol and drug abuse services may be dropped from benefit plans. Dropping these benefits does nothing to reduce hospital costs, and in the end may have the opposite effect.

Mr. Chairman, all of those in the private sector who have the most to gain from effective hospital cost containment - the employers, the unions, the insurers - in essence, all of those in the private sector on the paying side of the equation - say the employee health tax will be ineffective in curbing rising costs and are opposed to its enactment.

It is a fact that the medical expense people fear most is hospital expense, and it is hospitalization insurance that will be the last, and least, effected by this proposal.

The most sensible approach to keeping hospital costs under control is prospective payment reform that applies to all patients, not just Medicare patients. Rising costs are not just a Medicare-Medicaid problem but a national health care problem as well. A prospective all-patients system will force cost-saving incentives into the structure of hospital payments and operations and will have many times the impact of the band-aid approach of taxing workers' health insurance premiums.

We are beginning to see that prospective payment systems that include all-payers, including Medicare, now in place in four states, can work. There is no reason why the Congress should try the untested theory of taxing health insurance premiums--and every reason why it should not.

Again, HIAA and its member companies share this Committee's concern over rising health costs. We appreciate the opportunity to present our views. I will be pleased to respond to questions.

Senator **Jepsen**. Would you support the idea of a national health policy commission which was recommended by Mr. Califano earlier today?

Mr. **Dorsch**. Yes, we would. We have suggested in that past a Presidential commission composed of all the parties at interest, feeling that you need the expertise of hospitals, doctors, insurers, consumers, employers—all these as a practical matter that have political clout need to be part of the negotiations.

On the other hand, we also think that this is an immediate problem and it's such a large problem that there is no one way answer and we would hate to see such a commission delay implementation of other cost needed legislation such as we have already suggested.

Senator **Jepsen**. As more and more people move to the health maintenance organizations or the preferred provider organization systems providing health care, what does this mean to the traditional health insurance companies?

Mr. **Dorsch**. Well, they've responded in a number of ways and it's been a very interesting phenomenon.

First, the insurance companies, and the HIAA in particular, have supported HMO legislation in the past and companies individually have invested in HMO's, both owning and operating HMO's, or financing them or lending them money. So they see it as a good competitor. They see it as another way of helping to hold down costs.

One the other hand, while HMO's have increased their membership substantially, I'm not sure that they have taken a large share of the market as yet. In other words, we started with Kaiser right after the Second World War, and it hasn't been such a fantastic idea for everybody that they have yet taken over the world. I think they may be 8 percent of the market at this point. So that in any particular area, they have not been a real problem to insurers. It may be a problem as younger people in any particular company switch to HMO's, and it is usually, we have observed, primarily younger, more mobile workers that are more likely to join HMO's. Older workers with higher health costs may in fact stay with the traditional indemnity plans, assuming the employer has a multiple choice plan.

This doesn't present any real problem as long as the employer is paying the entire cost of the health plan. If he's paying both, there is no real problem. If there is a substantial employee contribution, however, you may in fact get some adverse selection, which means that because the cost to the older workers go up and the cost to the younger workers go down and you start creating economic problems within the plan which the actuaries have to cope with.

Senator **Jepsen**. Do you have any closing statement for the record? I appreciate your testimony. It was terse and right to the point and a good wrap-up and good creative ideas. Do you have any additional statement?

Mr. **Dorsch**. Well, I think you've had an excellent spread of witnesses here, many good things to say, and I think it is a problem that does have to be faced by the Congress. I want to commend you for taking hold of it, sir, and inviting us to be here.

Senator **Jepsen**. I thank you.

The purpose of today's hearing was to take a broad brush look at the health care costs and, in closing, I'd like to try to summarize what I consider some of the key points in this hearing.

First of all, I think all the witnesses presented some very thoughtful testimony which will give Congress a great deal to think about. I think we had an interesting cross-section of viewpoints that have been beneficial. Clearly, there is a great deal of debate over the question of whether we need to rely more on market solutions to the health care cost problem or whether we should turn to greater regulation. The problems we face are serious and, as was pointed out, the costs are only going to continue to rise and the longer we wait to get at the problem, the harder it's going to be to make these changes.

I'd like to mention that this is only the first in what I expect will be a series of hearings on this topic. I think the fact that there was so much interest in this topic is testimony in and of itself to the seriousness of the subject matter.

Going into today's hearing I did not expect to be able to walk away with the answers, but I think we've had some very interesting ideas placed before us for consideration.

So I would like to take this opportunity to thank those people who have been watching this hearing here and at home and let you know that the committee welcomes your comments as well. If you have any ideas on how to get at or how to get health care costs under control and you would like to bring them to the attention of this committee, you can write to this committee, to Senator Roger W. Jepsen, chairman of the Joint Economic Committee, Dirksen Senate Office Building, Washington, DC. The ZIP Code is 20510.

I thank all the witnesses for taking the time to be with us today and I look forward to the continuing dialog in the days and months ahead. I will ask that the record of this hearing remain open so that any witnesses who wish to do so may submit additional material before we close the record.

This hearing is now adjourned and subject to the call of the Chair.

[Whereupon, at 1:35 p.m., the committee adjourned, subject to the call of the Chair.]

HEALTH CARE COSTS AND THEIR EFFECTS ON THE ECONOMY

WEDNESDAY, AUGUST 29, 1984

Congress of the United States,
Joint Economics Committee,
Washington, DC.

The committee met, pursuant to notice, at 1:20 p.m., at St. Luke's Student Residence Auditorium, Cedar Rapids, IA, Hon. Roger W. Jepsen (chairman of the committee) presiding.

Present: Senator Jepsen.

Also present: William Finerfrock, legislative assistant to Senator Jepsen.

OPENING STATEMENT OF SENATOR JEPSEN, CHAIRMAN

Senator Jepsen. This meeting will come to order. We should never start anything by making an apology. Also they say if you have time to spare, go by air, and that's what happened in this case, but we are glad to be here and thank all of you for taking time out of your schedules, busy schedules for being here today. I would like to thank also St. Luke's Hospital for allowing the Joint Economic Committee to use this facility. To our witnesses and guests, I say welcome and I hope you find today's proceedings both informative as well as enjoyable. From the looks of our agenda, we have a busy day ahead and I will not take a great deal of time with my opening statement.

I would like to point out that this is the second in a series of hearings I have asked the Joint Economic Committee to conduct on health care costs. The first hearing was in Washington, DC, on April 12, 1984. The committee heard testimony from a wide variety of witnesses at that time representing providers, consumers, and the health insurance industry. Today's hearing will be similar in nature except that our witnesses will look at health care from an Iowa perspective rather than a national perspective.

I do believe the Federal Government can learn a great deal from Iowa. Our State has a great deal to be proud of in the area of health care and it is my hope that this forum will provide us with an opportunity to look at some of the things that make Iowa so unique.

In many ways, the health care debate in Washington is much like the weather, a lot of people are talking about it but nobody is doing anything about it.

There is no question that health costs are rapidly getting out of hand. It has now been estimated that the American people are spending approximately $1 billion each and every day on health care costs.

Several months ago, during a discussion on health care with a number of Iowans, someone raised the question: "Who's to blame for skyrocketing health care costs?"

One person in the group offered that it was the doctor's fault, another suggested that perhaps the hospitals were to blame. Still another suggested that actually it was neither, but rather it was the insurance companies that were driving up the cost of health care. I'm sure this is familiar and you've heard this type of roundrobin discussion before.

But as we discussed the matter further, we came to the conclusion that it was really unfair to blame just the doctors or the hospitals or the insurance companies; that indeed consumers, business, and Government were to share, if there was blame to spread around, were to share in it as well.

I suppose the question, "Who's to blame for skyrocketing health care costs?" can best be answered by the cartoon character Pogo who once stated, "We has met the enemy and it was us."

During today's hearing we will be listening to the people who make up that "us"—doctors, lawyers, hospital administrators, nurses, business, Government, and consumers.

As everyone in this room knows, however, rising health care costs are more than just statistics or dollars. Health care means people. For many years now it has been the policy of the Federal Government to try and see that health care in this country is a right, not a privilege. It was this obligation which led to the creation of the Medicare and Medicaid Programs. And it is this commitment that has led to some of the changes being made in our health care system today.

But up until now, we have tended to only look at the results of skyrocketing health care and not the causes. We have never had a clearly spelled out health care policy in this country but rather depended upon a variety of programs to come together and become a policy.

Congress and the administration now appear ready to tackle this major undertaking with joint cooperation and working together on it.

Your insights and observations will be a key to helping us develop an intelligent health care policy for this country. Let us learn from your experience and make improvements for the future.

Someone once described Washington as 14 square miles surrounded by reality. Well, I can't think of a better place to get a taste of reality than right here in Cedar Rapids, IA.

I welcome you all to this hearing and I look forward to your testimony.

We have four panels. One is a consumer panel, the first one, the second is provider perspectives, and the third is funding sources and the fourth is future planning. So as you see, our witnesses today do represent a wide variety of interests. We have individuals representing the Iowa Retired Teachers Association, the Iowa Medical Society, nursing homes, urban and rural hospitals, home health care, attorneys, insurance, Government, not to mention individuals testifying from their own experience from personal viewpoint as well as from business perspective. We will start right out with the consumer panel, and I would like to welcome at this time Julie Beckett from Cedar Rapids, who will be addressing a long-term care and home health needs; Jim Shipley, chairman, State Nursing Home Association, and next to him is Wayne Pos, the gentleman in the center, in the middle, with the yellow and blue tie and the blue jacket. Wayne Pos is a legislative representative for the Retired Teachers Association. And Denise, how do you pronounce that?

Ms. **ROQUETTE**. Denise.

Senator **JEPSEN**. Denise. It would help if I get the name right. Denise Roquette, Cedar Rapids; Jean Flanagan, Cedar Rapids; and Jim McLaughlin from Monticello. We will start with Julie Beckett, Cedar Rapids.

STATEMENT OF JULIE BECKETT, CEDAR RAPIDS, IA

Ms. **BECKETT**. I am supposed to speak on long-term care this afternoon mainly because my daughter was involved in a long-term care institution at St. Luke's for a long period of time. I am also involved in an organization which is helping to alleviate some of the problems that long-term care parents are having.

There are so many things to discuss when talking about long-term care. I often wonder where to begin, but of course I have to begin with Katie, for she is the reason I'm here at all.

Katie's history of being a long-term patient started 5 years ago after a bout with viral encephalitis which left her comatose, totally paralyzed and progressed her to become ventilator dependent. It seems hard to believe it's been 5 years, but when I watched her last Thursday put on her uniform and gather up her school things, I couldn't believe the day had finally come for first grade. For here was a child that a little over 2 years ago was strapped in the confines of the pediatric intensive care unit in this very hospital, limiting her exposure to other children, to a loving family, to a loving community beyond St. Luke's Hospital. We had reached a point in which Katie's life had become stagnant. There was nothing more for them to do, but maintain Katie's care at its current level. The nurses and therapist had taught Mark and I all about taking care of Katie's needs, and it was proposed Katie should go home, ventilator and all. It was a beautiful day, thinking Katie was finally coming home after 3 years of running to the hospital three and four times a day. You don't have much of a family life in an institution, even with one as caring as St. Luke's Hospital. But shortly after the joy of thinking about having Katie home, reality set in and dashed our hopes for a "normal" family life.

Money, "the almightly dollar," was going to keep us away from our little girl. Katie had incurred such expenses in her long struggle for life, far beyond what our insurance would pay, and had been placed on the Medicaid roles 7 months prior to her discharge. Medicaid rules had been allowed to apply to Katie because she was an individual and not living under our income. When Katie left the institution her status would again come under our dependency and we earned too much money to allow Medicaid to help with further health care expenses, even though we could never earn enough to pay for her in-house and in-home hospital costs. We were caught in the typical "Catch 22." We went through the normal channels to try and get an "exception to policy" from the Department of Health and Human Services. We had to review the brushes with death that had occurred throughout Katie's life. We gathered statistics to show the cost effectiveness in home health care. We did everything we could to convince them that this was going to be so much better for Katie and her family if they could allow her to come home on Medicaid status.

After a very frustrating spring, summer and fall, we received a rejection to our "exception of policy" plea. But, we had one person in our corner who had taken the time to listen to Mark and I, and to meet Katie. His name is Tom Tauke. Congressman Tauke had supported the idea of filing for an "exception to policy" and had even gone so far as to have a staff person work with Health and Human Services to gather statistics to show the cost-effectiveness. In late October, it was Tom's office that had received the rejection first. The Congressman then took matters into his own hands by going directly to the Vice-President who was heading the Regulatory Reform Commission. Here was a perfect example of where Government failed the common man. The rest is history. The President learned from the Vice-President and in a news conference on November 10, 1981, used Katie as an example of how "hidebound regulation" forced Government to be inhuman.

I'm very proud to say that since then, many persons have been allowed to receive a waiver to allow them to leave institutions and thrive in the environment of a caring, loving home. What we have seen from this is the prognosis improves dramatically. With Katie alone, one area affected—her speech—has improved so much so, that she no longer needs sign language and can be mainstreamed in a first grade classroom where other children can learn about life of a "disabled" person.

Katie has been set as an example for home health care. She has improved so much, that the ventilator which was needed 16 hours a day when she first came home, is now only approximately 7 or 8 hours a day. We don't refer to her as ventilator dependent, but ventilator assisted.

She still needs a daily regime of activity to keep her status quo and Mark and I perform that as a part of our daily routine. It's not without worry and strain, but is all worthwhile and we would not and could not go back to life before home health care. Everyone in this community has been affected by Katie's progress. Everyone takes pride in what "we" have all done for her.

When Katie first left the hospital, all contacts had been made with speech therapist, physical therapist, occupational therapist, vendors, suppliers, all to meet the needs Katie had. Over the years these needs have had to be revised, but they are still in actuality. Her care plan has been flexible enough for growth and because of that she has succeeded to become the active participant in our society, not a burden to our society.

What about other cases in Iowa? Well, without the coordination of services, families cannot take on the added needs of technically assisted children at home. We are very lucky in Iowa to have many of those services already in place, but it is connecting the child up to the appropriate persons that does not always happen. I felt up until last Thanksgiving that things were going fairly well, but then I learned of a family with the same problems we had with Katie, struggling to make it through the systems. I realized then that family support, informational resources and education of parents and professionals about home health care needs was an absolute to successful home care planning in our State. Since then I have organized a SKIP chapter for the State. SKIP means Sick Kids Need Involved People. I have worked on the Federal level by identifying needs families are having all over the country. I have worked to encourage other States to develop waiver programs for all persons, and I have worked with our own State crippled children services to establish a regionalized plan for home health care for children with chronic long-term illness. I am hoping with this health care plan, services will be united, working together to help families meet the needs of their children while communities grow in the pride of helping one another and share in the successes as these children nurture to become responsible dedicated citizens. Thank you.

Senator JEPSEN. Thank you, Julie. Now, Mr. Jim Shipley on the concerns of the elderly population. I would advise the members of the panel that your prepared statements will be entered into the record, and you may therefore summarize or proceed in any way you may desire, but please know that your statements will be entered into the record, and then you can do what you want. Mr. Shipley.

STATEMENT OF JAMES E. SHIPLEY, PRESIDENT, IOWA HEALTH CARE ASSOCIATION, ANAMOSA, IA

Mr. SHIPLEY. Senator Jepsen, ladies and gentlemen, I appreciate the opportunity to address you today and present my thoughts and observations on the concerns our elderly population have in regard to their current and future health needs. In my day-to-day activities as president of the Iowa Health Care Association and as a provider of long-term care services to many Eastern Iowa elderly and handicapped citizens, I feel adequately prepared to present their concerns to you.

It will probably come as no surprise to you that financial security and health are the top concerns of our senior citizens, and not necessarily in that order of importance. I find that a high percentage of our elderly are very well aware of the problem of high costs associated with our current health delivery system. They understand that the system will need to be changed in the future but they are apprehensive and have questions such as:

First: What will be the availability of future services and where will the resources come from to pay for them?

Second: Do we view quality health care as a right or a privilege?

Third: Will we be able to maintain our independence in making decisions relating to when and where we may seek services?

Fourth: Will we in rural Iowa have access to quality and high tech services in our home areas or will we have to relocate to say urban areas to receive such care?

Fifth: What about quality of life? We are aware that the ability to sustain life through the use of technology outstrips our ability to make prudent decisions regarding when to sustain life.

These are but a few of the questions our elderly citizens are asking but they are perplexing ones that need to be addressed in the near future. The problem of affordable quality health care for the elderly will only intensify in the future. Inasmuch as personal health services are rendered to individual people, the demographic characteristics of Iowa and the nation are basic to understanding changes in the delivery of health services now taking place. This understanding is even more crucial to planning for future delivery resources to meet future population characteristics.

The State of Iowa is in the midst of profound demographic and social changes. These changes will alter individual and household behavior and directly impact the demand for health care services for our elderly. While the population for the entire State of Iowa grew 3 percent during the last decade, the number of people 65 and older increased 11 percent and now represent a total of 13 percent of the State's total population. The younger people are moving out of the State in significant numbers and those over 65 tend to remain in their place of residence. Iowa now ranks fourth in the Nation in terms of percentage of population over 65; these are the citizens whose needs for health care will increase since statistics demonstrate repeatedly that older people tend to need health services at least twice as often as the younger population.

The Center for Hospital Finance and Management at John Hopkins University commissioned a report which shows that with life expectancies increasing at their current rate, the numbers of persons over 85 years of age will increase by 75 percent during the next 20 years for the Nation as a whole. In Iowa the population 85 and older is expected to double by the year 2020.

With these demographics in mind, it becomes obvious that one of the most important problems for us to solve in the next two decades is how to balance the health care needs of a growing elderly population against the diminishing ability of the working population to pay for it.

What is so obviously needed is long range planning on both the national and State levels. Within the present system it is possible that very few services would be available to the elderly and poor Iowans in the future as the health care expenses of our elderly are very largely paid by Medicare, Medicaid and other Government programs. Shortages of funds for these programs will cause the Government to respond to the crisis. A better approach is to recognize the problems now and develop a plan to solve the problem in a rational way rather than to plan by default.

No one entity will be able to respond to the problem of assuring affordable quality health care for our deserving senior citizens. It is a societal problem which must be approached by every segment of society. But we need a leader in these efforts and I certainly hope our United States Senator, will assume this role. Thank you.

Senator JEPSEN. Thank you, Jim. As long as we got the microphone down there, put it on Jim McLaughlin. James McLaughlin, emergency health care, from Monticello. Jim, please proceed.

STATEMENT OF JAMES N. McLAUGHLIN, MONTICELLO, IA

Mr. McLAUGHLIN. Senator, can you put a price on the unnecessary loss of a human life? To the Government it may be the loss of several thousand dollars in taxes annually. To the local merchant it could mean products not purchased. But to the family it is a tragedy of epic proportions—whether it be the father, not saved from a heart attack, a mother or child lost in an automobile accident, or a badly burned fire victim arriving too late for treatment.

The big news is that the air ambulance saves time and it saves lives—and it does it day after day, year after year.

It is the chain that ties the small hospital to the larger, better equipped city hospital. It is the reason that I am visiting with you today, after nearly dying of a heart attack approximately 2 years ago.

Yes, I can personally testify to the speed of the bird, the dedication and efficiency of the personnel, and the comfort that comes from knowing that you are in competent hands and that everything is being done for your well-being that it is possible to do.

In no way do I want to belittle the role of the local ambulances or the local hospitals. They all form vital links in the safety chain, but the big bird is like Superman, able to leap the tallest buildings and ignore the busy highways below. Whenever there is an emergency, and time is of the essence, the lifeguard ambulance needs to be available.

Traveling on the lifeguard is not something that you fear, the attendants had me prepared and ready to depart in a matter of minutes. I am told that it takes approximately 15 minutes to travel from the Monticello Hospital to St. Luke's where I was treated. I did not time it, nor did I worry, as I had complete confidence in the men and in their life-sustaining equipment.

In a very short period of time I was hooked to the monitoring systems of the hospital and had all their lifesaving techniques at my disposal. But this is not about the hospital, it concerns the men and the whirly bird who are ready to quickly transfer accident victims and all who are in medical need to the areas of special lifesaving equipment.

We have always been told that a chain is as strong as its weakest link. The lifeguard plane is the secure link that may have saved my life yesterday and may save yours tomorrow.

Emergencies do not announce their coming in advance. Not one of you in this audience today can guarantee that tomorrow or in the near future you will not be the one needing quick transportation to an emergency facility. I live on a farm west of Monticello and we often see the helicopter as it passes near our farm. Two of our immediate neighbors have also had this lifesaving ride.

If you are asked to contribute to the air ambulance, in order that it will always be able to fly, do so. If taxes are needed, I can think of no better place to use them. If a government grant is needed, let us urge our leaders to support it. Let us put our energies and our dollars to a positive purpose—that of saving lives. I, for one, can endorse that program.

Senator JEPSEN. Thank you, Jim. Wayne Pos, legislative representative of the Retired Teachers Association.

STATEMENT OF WAYNE POS. LEGISLATIVE CHAIRMAN, IOWA RETIRED TEACHERS ASSOCIATION, DES MOINES, IA

Mr. POS. Thank you, Senator, members of the panel, and friends. Probably some of the ideas which I will proceed to give will answer some of the questions Mr. Shipley raised and maybe some of the questions which were raised by two of the previous speakers.

However, all the answers aren't here. All the questions haven't been asked. As a senior citizen, I feel that I have some right to speak as a senior citizen for senior citizens. The health care industry is one of the largest and fastest growing sectors of the U.S. economy. I just about changed that spelling to specter. Since 1967, heath spending has increased on average over 12 percent per year while the economy as a whole has grown at only 9 percent per year. Health care spending has taken a larger share of the Nation's total resources—rising from 6.4 percent of GNP in 1967 to 10.5 percent in 1982.

In 1982 hospitals continued to receive the largest share—47 percent—of the $287 billion, more than I can comprehend, spent for personal health care services. Moreover, hospital costs and revenue continued to increase at double digit rates. Over the past 5 years, hospital room rates have increased at 2½ times the general rate of inflation.

Over the past 3 years, Congress has enacted approximately $25 billion in Medicare spending reductions. To date, these spending reductions have been achieved through increases in beneficiary cost-sharing—that is, increases in part A and B deductibles and coinsurance—which increase their direct out-of-pocket payments for health care services and through limitations in the amounts which Medicare pays to hospitals and physicians. Here are just a few of the ideas I would like to have you consider. To restrain the rate of increase in total health care spending, the following cost containment strategy should be pursued: First, the rate of increase in hospital expenditures should be limited to a fixed percentage rate that is reasonably in line with the general inflation rates. The limit once established should apply to all third-party payments to hospitals. Second, the economic incentives that are causing excessive expanion of conventional medical facilities, particularly hospitals, should be removed: For example, by imposing limits on depreciation deductions when hospital/nursing homes are sold. Third, health care service delivery should be restructured away from acute-care institutional settings, with greater emphasis placed on preventative, community-and-home-based services. Fourth, Government regulatory programs with the potential to yield significant savings should be promoted along with effective measures to promote competition in the health care industry.

Over the long run, health care delivery should be restructured to expand the supply of needed services that represent less costly alternatives to hospitals and nursing homes. Competing forms of care delivery such as health maintenance and preferred provider organizations, small clinics, and ambulatory health care facilities of all kinds should be encouraged to the extent possible. Greater use should also be made of paramedical personnel—for example, geriatric nurse practitioners and physician assistants—especially in under-served rural and inner-city areas and in such neglected institutional settings as nursing homes. For the elderly, this kind of restructuring would mean better access not only to conventional medical care but also to a variety of needed nonmedical, social services, like homemaker/chore maintenance services and nutrition counseling services.

As part of the Social Security Amendments of 1983, Congress has enacted a prospective payment plan to compensate hospitals for services they render to Medicare inpatients. The Medicare prospective payment system uses a case mix approach, DRG, diagnostic related groups, to determine the amount of payment a hospital will receive with respect to any particular patient case. The amount of payment is based on rates calculated for each DRG. If a hospital spends more than its DRG rate for a specific diagnosis, it loses money. If it is able to treat the patient for less, the hospital keeps the savings. This is a good step in the right direction.

However, hospitals will attempt to shift any unrecovered costs they incur with respect to Medicare inpatients to non-Medicare inpatients and their private third-party payors. This could mean that the DRG system will have little or no impact on aggregate hospital cost escalation---at least until the DRG, prospective payment plan is made applicable—as it should be—to all third-party payors.

We believe that hospitals can contain costs, deliver high quality care and earn a surplus sufficient to maintain viability while receiving less revenue than otherwise under the cost-plus reimbursement method.

Physician charges are the major out-of-pocket health care expense for the elderly. Sixty percent of physician charges are paid directly out-of-pocket.

To help stem the elderlies' rapidly rising out-of-pocket expenses, gaps in Medicare benefits should be closed. An effective cost containment program, along with a substantial reduction in provider fraud and abuse, could help pay for the extension of Medicare benefits to include some of the currently noncovered items, and services or services that are subject to durational limitations.

The elderly—I can speak very forcefully about this—are major consumers of prescription and over-the-counter drugs and therefore have a keen interest in legislation affecting drugs, especially drug prices. Drug manufacturers are supporting legislation to extend the term of patient protection for prescription drugs. We strongly oppose legislation to increase the term of patient protection for prescription drugs.

We oppose deregulating the Nursing Home Industry.

The last paragraph summarizes it all. All of us are well aware of the rising cost of long-term care. However, that problem is associated with the aging of the population and the cost escalating factors unique to the health sector of the economy. It should be viewed not as a problem for the individual or the individual's family, but as a problem for society as a whole. Thank you.

Senator **Jepsen**. Thank you. And now Denise Roquette, Cedar Rapids, proceed.

STATEMENT OF DENISE ROQUETTE, CEDAR RAPIDS, IA

Ms. **Roquette**. Thank you, Senator Jepsen. My name is Denise Roquette. I am fulltime, single, working mother with two children ages 11 and 4. My monthly salary is $428.00. Out of that $428.00 comes food, utilities, rent, clothing, child care; and other necessities. I hardly have enough to meet those expenses, not to mention medical expenses.

An office call is anywhere from $18 to $25. The office call does not include prescription if it is needed which can be as high as another $20 to $30.

Just recently my daughter was very ill. Since it was after doctors' hours, I had no choice but to go to the emergency room not once, but twice, as well as her family doctor the next day at a cost of $300. As you can see, that is well over half of my monthly salary.

Physicians now require payment due with each visit. For myself, this is almost impossible.

I'm sure that I'm not the only person in this situation and do not want to quit my job to qualify for title XIX. It would seem to me for people who are trying to maintain a job and take care of a home and children too, there should be some kind of guidelines or a sliding scale on what we can afford to pay. As you know, you have no choice when you or someone in your family becomes ill, you have to go to a doctor.

I'm not asking for a handout, as I'm sure other people facing the same dilemma as I am are not. However, the fact remains medical expenses are and have been on the rise. Myself and others like me could use some help. Thank you.

Senator JEPSEN. Thank you, Denise. Jodi Miller, Cedar Rapids.

STATEMENT OF JODI MILLER, CEDAR RAPIDS, IA

Ms. JODI MILLER. Thank you, Senator Jepsen. From March, 1979, until February, 1980, I was employed by Fleetway Stores, Inc. My hourly wage was $3.15 per hour and I worked 37½ hours per week. This was my only source of income other than $25 per week that I was supposed to receive for child support. In a 4-week month my total gross income—including child support, which I sometimes did not receive—was approximately $573.

My health insurance was fully paid by the company, but my daughter's was not. The only additional coverage I could purchase through the company was a family plan which would have cost an additional $63 per month. So, I purchase a separate Blue Cross/Blue Shield 80/20 plan policy for my daughter which cost $40 per month.

My monthly expenses of which rent, utilities, and telephone were shared were: $195 rent, $12 electricity, $15 telephone. My cost for baby-sitter was $120, $120 for gas to transport my daughter to the baby-sitter and get me to work, $65 auto payment, $32 auto insurance and $40 health insurance. Total monthly expenses were approximately $599. After paying my half of the rent, utilities and telephone, I had approximately $83.50 to purchase food and cover our medical expenses, which at that time amounted to approximately $50 per month. In addition, if I did not receive my child support for 1 or more weeks that month, I couldn't even cover food or additional medical expenses.

I called Social Services and filled out an application for A.D.C. and food stamps while I was still working. I was denied any help because my income was too high. So, I felt that my only alternative was to quit work and to go on A.D.C. My share of the expenses were then reduced to $208.50 per month. I did not have the cost of baby-sitter nor transportation. I received $292 per month A.D.C. and $77 per month in food stamps. Most important though was title XIX which covered almost any medical expense I incurred.

I would like to add that since the beginning of the year, my family physician cost $377, my daughter's pediatrician has cost $177. Between the two of us, we had four different specialists, a neurologist, Dr. Risk, which cost $460; Dr. Boatman and Dr. Devine which cost $270 and $250; and Dr. Zoler, $185. This amounts for about $1,700 since the beginning of the year, which had I been working, I would have never been able to pay for, and it's been all covered from title XIX. Thank you.

Senator JEPSEN. Thank you, Jodi. And now, Jean Flanagan.

STATEMENT OF JEAN FLANAGAN, CEDAR RAPIDS, IA

Ms. FLANAGAN. Senator Jepsen, ladies and gentlemen, I have been listening to the other people speak, and I have gone through an experience with my father, who was a senior citizen, passed away July 23. I am afraid my report is a little different than some of these, because of the situation which prevailed with us. I am here to report my personal experience with the illness and death of my father, Cleo Fahrney. He was admitted to the hospital April 2, 1984 and died in an extended skilled care facility July 23, 1984. I realize there are reputable care facilities with qualified employees, but my experience was a very bad one. This care center is for veterans on extended care, private pay people, and patients who cannot stay in the hospital due to changes in the Medicare Program.

My father was admitted to the hospital and diagnosed as a cancer patient. He was 86 years of age, still employed at the time he became ill and had worked the morning he went to the hospital. I sat with him 12 or 13 hours a day every day until his death. He was allowed to stay in the hospital 30 days, then we were told we had 3 days to take him somewhere else, even though he couldn't walk anymore and had lost 20 pounds. Many mistakes had been made, but the ordeal changed from terrible to pitiful.

The following are some of the complaints I registered with the State Department of Health: The food was of poor quality and prepared very bad. The day the State investigated, they had people there from the home office and a good meal was served. Medications were not given correctly. Due to my father's difficulty in swallowing, his pills were to be mashed and given in applesauce. Charts are not referred to many times, and I would have to tell them this had to be done or he would choke.

One day when I arrived, he was trying to eat his breakfast and they had put his teeth in upside down. There was a great misuse of enemas, laxatives, and suppositories. People were given them and left to go in the bed or left in the bathroom for a long time. When we first arrived, my father was left in a bathroom for 2 hours in the middle of the night. He called for help until he was hoarse. When it was reported, a rude response was given back that he should have turned on the light. I checked the light and found the cord was broken. I felt it had been that way some time because the cord was frayed. He also was left on bedpans for long periods and given enemas and left with the result in his bed. He never complained, but he would ask me for help. After it was discovered he was allergic to the suppositories used, his doctor gave orders never to use them again. During the night, not once, but on two different occasions, he was given a suppository. He went through terrible suffering from this. They either didn't check the chart or ignored the doctor's order. One of the aides told me she was so sorry and she had begged them not to do this because she had seen it on his chart.

I have observed many instances of what I consider abuse and will leave this information for you. My feelings in this are not only personal for a terrible ordeal by my father which he had to endure, but I have lost two fine husbands in war, fighting for this country and what it stands for, and something is wrong that we are letting our sick and elderly people and ailing veterans go through this kind of treatment. The door is open for unscrupulous people to use the life savings of people who need care but instead are receiving misery or even death.

The State Department of Health does investigate complaints and requests correction. However, this course of action would not be necessary if they were more closely monitored. It is correct Medicare has been misused, but there must be some other way to correct the situation other than what is happening now. Compassionate health care for our sick and elderly must not only be a goal, but a commitment.

Senator **Jepsen**. Thank you. Ms. Beckett, every time I hear Katie's story, it reinforces my belief that one of the great things about this country is that one person can make a difference. And so often we become cynical and begin to believe that unless we are part of a large organization or some big movement, we can't change. But your story reminds us all that with dedication and determination, you can make a difference, and it also reinforces the fact of regardless of what a person's lot in life is or his responsibility is, his or hers, or what title they may have, that people are, the bottom line, for the most part, are very caring and compassionate and do whatever they can. The organization you mentioned, the SKIP, which is Sick Kids Need Involved People, is that established nationwide now or have you got this local?

Ms. **Beckett**. It's a national chapter, but it's only established at this time in 14 different States and there are three chapters in—

Senator **Jepsen**. What's its primary funding source?

Ms. **Beckett**. Well, at this time, it's working through a couple of demonstration grant projects, mainly through the Department of Health and Human Services but it has also received Federal funding grants, from various private funders from the private sector.

Senator **Jepsen**. I suppose the last question I could ask is what should the Government be doing to be more responsive to the needs of the future Katie Becketts?

Ms. **Beckett**. I think at this time the Government is working very closely—I think there are people, at least that I am working with, are able to listen to the parents that are out there in terms of home health care. What we need to do on a State by State basis, and that's why it's been established that way, is to allow the parents that are in those States to express the problems that are going on and get the answers to those questions, to get the professional with the family so that the problems—for instance, one of the problems that we found here was with a vendor-supplier that one of our families had, and in the middle of the night the little girl needed oxygen—well, she needed to be suctioned. She could breathe, but she needed to be suctioned to clear herself.

And the machine broke down in the middle of the night and the mother called the vendor and said my suction machine is broken, I need a suction machine, and he said I am not a 24-hour vendor so I am not coming out. And she was—you know, she basically didn't know what to do. So she called me and I said take her back to the hospital. I mean there is nothing else this girl could have done at the time. The suction machine was broken, the girl cannot make it through the night without being suctioned several times, and yet the promise was made by the vendor that he was a 24-hour dealer. Well, that's not right and those kinds of situations have to be resolved. The families themselves have to realize who are the appropriate people that they need to get out here, and so that's what SKIP is mainly doing, is working as informational and referral for a lot of the parents, as a family support, and also to educate parents and professionals that home health care can work as long as the services are out there and those—the needs that these people have can be met. I mean in Iowa especially there are so many services already out there, but it's just connecting the person with the service. Does that help answer your question?

Senator **Jepsen**. Do you want to make any comments, Mr. Shipley, on any——

Mr. **Shipley**. I have no further comments.

Senator **Jepsen**. All right. Well, I thank all of you for your testimony. The way we do form policy and change things is through the collection of both people's experiences and their expertise, and as these things build up and are researched and reviewed, that's the way that ideas come for making changes, and there may be some that may come out of meetings such as this today. Collectively here I think we have got on a consumer base which is quite a dramatic cross section of information. I thank all of you for coming, and you are now excused, and have a safe trip home.

Is there anyone that has any closing statement? I should ask you that.

I now ask Dr. Swaney, Linn County Medical Society; Samuel Wallace, president, St. Luke's Hospital; Sally Miller, administrator, Anamosa Community Hospital; Gary Levitz, assistant director, University of Iowa Hospital and Clinic; Jim Tinker, administrator, Mercy Hospital, Cedar Rapids; and Judith Muenchow, executive director, Public Health Nursing Association.

I welcome you to the panel and advise you that your prepared statements will be entered into the record, and you may summarize or proceed in any manner you so desire. We will start with Dr. Swaney, Linn County Medical Society.

STATEMENT OF ROBERT L. SWANEY, M.D., PRESIDENT, LINN COUNTY MEDICAL SOCIETY, CEDAR RAPIDS, IA, REPRESENTING THE IOWA MEDICAL SOCIETY

Dr. **Swaney**. Senator Jepsen, I am currently president of the Linn County Medical Society and am here today representing over 3,200 members of the Iowa Medical Society.

Senator Jepsen, the Iowa Medical Society welcomes the opportunity to participate in today's forum for health care issues.

There is no question that the health care system has become a major component of the American economy. In addition to the frequently cited figure of health care income contributing to over 10 percent of the gross national product, we note the health services industry is responsible for employing 5.2 million full-time equivalent positions and ranks second among the Nation's industries behind retail trade. In Iowa, hospitals and other providers of health care services may be the major source of employment and income for the local community. We must recognize also that a high quality health care system is needed locally to attract and keep business and industry.

We believe there is merit in asking whether the devotion of 10 percent of the GNP to health care services is too much. The purchase of alcohol and tobacco accounts for 3.8 percent of the GNP and recreation accounts for 6.4 percent. Taxes account for over 20 percent of the GNP.

It is important to recognize in any discussion about the impact of health care costs on the economy that we not lose sight of the great advances that have characterized our Nation's health care system and the benefits that have been provided to our society. For example, the life expectancy of Americans has increased significantly in recent years.

Many childhood diseases have been virtually eliminated. Since 1970, deaths from heart disease have declined by 25 percent and deaths from stroke have declined by 40 percent. While cancer remains a major threat, patients are living longer after treatment and many forms of cancer, formally viewed as inevitably leading to death, are now curable.

The modern miracle of transplant surgery provides life and hope to people otherwise facing death prolonged hospitalization or a deteriorating quality of life. Artificial hip joints have become almost routine, relieving over 65,000 patients of chronic pain last year alone.

New technologies also obviate the need to use more risky invasive diagnostic procedures.

Senator Jepsen, the United States has developed a medical care system that is a benchmark against which others are measured. We believe that increased resources dedicated to health care is a reflection of a maturing and humane society that places increased emphasis on the protection of its vulnerable population, including the ill and injured.

We recognize the need to restrain increases in the cost of health care. But we must also recognize an inevitable increase in the demand for health care services in coming years. Mr. Shipley has given some statistics concerning the increasing number of elderly. As the population ages, demands for health care services correspondingly increase, and the total cost for providing those services increases.

There are no simple solutions to solving the health care cost dilemma.

One solution not acceptable to the Iowa Medical Society is the rationing of care or caps on expenditures to achieve arbitrary reductions in health care expenditures. We also recognize, however, that health care services should be examined for their cost effectiveness. We have been taking positive actions to review the delivery of health care services and to eliminate those health care costs that are inappropriate and are not benefiting the public.

For example, the efforts of the Iowa Foundation for Medical Care, the physician organization responsible for reviewing hospital utilization in Iowa, have resulted in significant reductions in hospital utilization for patients covered by private insurers, Medicare and Medicaid alike.

This spring the Iowa Medical Society endorsed a call by the American Medical Association for all phyicians to voluntarily freeze their fees for a 1-year period and to continue to take into account the financial circumstances of each patient, particularly the unemployed, the uninsured and those under Medicare—and to accept reduced fees when warranted.

We believe cost savings can be accomplished without unnecessary Federal regulation. A key element of current health problems is nearly universal coverage of medical expenses by health insurance or government health programs which has insulated most Americans from consideration of the cost of medical services. Many economists have said that this partially is responsible for the continuing rise in medical care costs.

To help assess and guide Federal legislative proposals impacting on the Nation's health insurance system, the AMA has developed a set of principles which spell out a policy for greater individual choice and for incentives for prudent behavior by individuals. These principles are attached to my prepared statement.

Senator Jepsen, we realized that Congress needs assistance from the public in making any determination on how health care services should be delivered in this country in the future. To this end, the American Medical Association has taken the first step by initiating a project to create a future health policy agenda for the American people. This project is designed to develop a philosophical and conceptual framework as a basis for particular action plans and proposals that are responsible to the particular social, economic, scientific, educational, and political circumstances facing health care decisions. Some details of this project are included in my prepared statement.

In summary, Iowa is a State with a high proportion of elderly and rural residents. Government policy must assure that more, not less, health care services are available to serve our increasingly aging population, and that access to health care in rural Iowa is maintained, not reduced. The personal and economic health of Iowans depends on it.

We recognize the responsibility of physicians not only to maintain access to high quality health care, but to deliver it in a cost-effective manner. We hope to accomplish this with business, labor, Government, and other interested groups through our individual efforts, through the Linn County and Iowa Medical Society, and through the American Medical Association.

[The prepared statement of Dr. Swaney follows:]

Prepared Statement of Robert L. Swaney, M.D.

I am Robert Swaney, a medical doctor in family practice here in Cedar Rapids. I am currently president of the Linn County Medical Society and am here today representing over 3,200 members of the Iowa Medical Society.

Senator Jepsen, the Iowa Medical Society welcomes the opportunity to participate in today's forum for health care issues. We note with you the proportion of the gross national product being devoted to health care services now exceeds 10 percent. We also see with you the initiation of efforts to limit further the expansion of the health care delivery system.

There is no question that the health care system has become a major component of the American economy. In addition to the frequently cited figure of health care income contributing to over 10 percent of the gross national product, we note the health services industry is responsible for employing 5.2 million full time equivalent positions and ranks second among the nation's industries behind retail trade. In Iowa, hospitals and other providers of health care services may be the major source of employment and income for the local community. We must recognize also that a high quality health care system is needed locally to attract and keep business and industry.

We believe there is merit in asking whether the devotion of 10 percent of the GNP to health care services is too much. The purchase of alcohol and tobacco accounts for 3.8 percent of the GNP and recreation accounts for 6.4 percent. Taxes account for over 20 percent of the GNP.

It is important to recognize in any discussion about the impact of health care costs on the economy that we do not lose sight of the great advances that have characterized our nation's health care system and the benefits that have been provided to our society. For example, the life expectancy of Americans has increased from 69.7 years in 1960 to 74.5 years in 1982. Infant mortality has been reduced to a record low of 11.2 per 1,000 live births, less than half the figure in 1960.

Through the development of and widespread availability of vaccines, polio has been virtually eliminated, the incidence of mumps has fallen from over 150,000 cases as recently as 1968 to 3,285 last year, the cases of measles has declined from 481,530 in 1962 to 1,436 in 1983.

Since 1970, deaths from heart disease have declined by 25 percent and deaths from stroke have declined by 40 percent. These advances have come through major technological advances including open-heart surgery, pacemakers, new drugs, and greater public consciousness of the importance of proper exercise and diet. While cancer remains a major threat, patients are living longer after treatment and many forms of cancer, formally viewed as inevitably leading to death, are now curable.

The modern miracle of transplant surgery provides life and hope to people otherwise facing death, prolonged hospitalization, or a deteriorating quality of life. New hearts are transplanted into 100 Americans per year and 5,000 people receive transplanted kidneys. In 1983 there were 23,000 cornea transplants returning sight to those whose vision was severely impaired. Artificial hip joints have become almost routine, relieving over 65,000 patients of chronic pain last year alone.

New diagnostic devices such as CAT scanners, ultrasound, and nuclear magnetic resonance have greatly enhanced our ability to make rapid and more accurate diagnoses. New technologies also obviate the need to use more risky invasive diagnostic procedures.

Senator Jepsen, because of past public policy geared toward the expansion of our health care system and the greater availability of health care to more Americans, the United States has developed a medical care system that is a benchmark against which others are measured. We believe that increased resources dedicated to health care is a reflection of a maturing and humane society that places increased emphasis on the protection of its vulnerable population, including the ill and injured.

We recognize the need to restrain increases in the cost of health care. But we must also recognize an inevitable increase in the demand for health care services in coming years. We cannot afford to ignore the fact that between 1983 and 2025 the total population is projected to grow by almost 30 percent, with the elderly population doubling to a total of 58 million or 19.4 percent of the total population. Among the elderly, the group over age 75 will also experience substantial growth; 40 percent of the elderly are now older than age 75: and this figure will increase to 45 percent in 2025. The over age 85 group will triple from the current 2.5 million people to 7.6 million people in 2025. This substantial increase in the elderly population, which will be particularly significant in the State of Iowa, will result in a greater utilization of health care resources. Statistics indicate that individuals over age 65 are more likely to be hospitalized than those under that age. They also use more hospital days per hospitalization and they visit their physician and other health care practitioners more frequently. The importance of these figures is clear. As the population ages, demands for health care services correspondingly increase, and the total cost for providing those services increases.

There are no simple solutions to solving the health care cost dilemma at a time when more services are needed; technological advances, though costly, are resulting in increases in the quality and length of our lives; and the availability of high quality health care must remain accessible to rural Iowans, not only for their personal health, but economic health as well.

One solution not acceptable to the Iowa Medical Society is the rationing of care or caps on expenditures to achieve arbitrary reductions in health care expenditures. We also recognize, however, that health care services should be examined for their cost effectiveness. We have been taking positive actions to review the delivery of health care services and to eliminate those health care costs that are inappropriate and are not benefiting the public.

For example, the efforts of the Iowa Foundation for Medical Care, the physician organization responsible for reviewing hospital utilization in Iowa, have resulted in significant reductions in hospital utilization for patients covered by private insurers, Medicare and Medicaid alike.

This spring the Iowa Medical Society endorsed a call by the American Medical Association for all physicians to voluntarily freeze their fees for a one year period and to continue to take into account the financial circumstances of each patient, particularly the unemployed, the uninsured, and those under Medicare—and to accept reduced fees when warranted.

We believe cost savings can be accomplished without unnecessary Federal regulation. The evolution of our system of payment for health care has seen work place-based health insurance emerging as the primary means by which most Americans pay for health care services they receive. The nearly universal coverage of medical expenses by health insurance or government health programs has insulated most Americans from consideration of the cost of medical services. Many economists have said that this partially is responsible for the continuing rise in medical care costs.

To help assess and guide Federal legislative proposals impacting on the nation's health insurance system, the American Medical Association has developed a set of principles which spell out a policy for greater individual choice and for incentives for prudent behavior by individuals.

Senator Jepsen, we realize that Congress needs assistance from the public in making any determination on how health care services should be delivered in this country in the future. To this end, the American Medical Association has taken the first step by initiating a project to create a future health policy agenda for the American people. This project is designed to develop a philosophical and conceptual framework as a basis for particular action and plans and proposals that are responsive to the particular social, economic, scientific, educational and political circumstances facing health care decisions.

The first phase of this project, the development of principles, is now nearing completion, and the work groups are now in the process of identifying issues as the next step to developing action plans to carry out the principles.

This activity involves approximately 150 organizations including representatives of medicine, government, nursing, labor, business, the hospital industry, the public, and health care insurers. Through this broad-based organizational body, the American Medical Association hopes to be able to present Congress with viable principles and working programs for the development of a future health policy agenda that will assure the availability of high quality health care services for the American people.

In summary, Iowa is a state with a high proportion of elderly and rural residents. Government policy must assure that more, not less, health care services are available to serve our aging population, and that access to health care in rural Iowa is maintained, not reduced. The personal economic health of Iowans depends on it.

We recognize the responsibility of physicians not only to maintain access to high quality health care but to deliver it in a cost effective manner. We hope to accomplish this with business, labor, government and other interested groups through our individual efforts, through the Iowa Medical Society, and through the American Medical Association.

AMERICAN MEDICAL ASSOCIATION CONSUMER CHOICE PRINCIPLES

1. *Employment-Based Health Insurance.*—The growth of employment-based group health insurance for employees and their families should continue to be encouraged through tax incentives.

2. *Adequate Benefits.*—Each health insurance plan offered to employees should contain adequate benefits, including catastrophic coverage. Plans which do not have adequate benefits should not qualify for tax deduction as a business expense for the employer.

3. *Multiple Choice of Plans.*—Health insurance plan options, with varying levels of coinsurance and deductibles, should be available to employees; accordingly employers, through tax incentives, should be encouraged (but not required) to offer employees a choice of several health insurance plans. Multiple options will better meet individual and family needs and encourage greater individual responsibility in utilization of medical care services.

4. *Equal Contributions.*—Equal employer contributions should be made for health benefit plans, regardless of the plan selected by the employee.

5. *Limitation on Tax Deductibility of Excessive Health Insurance Premium.*—A limit should be placed on the amount of health insurance premiums paid by an employer that would be tax exempt income to the employee, as with life insurance. This amount should be high enough to provide for adequate benefits and should be adjusted for inflation. In order to discourage over-insurance and "first-dollar coverage" which can cause increased demand for care, amounts paid by the employer in excess of the limit would be taxable income to employees.

6. *Rebate to Employees.*—In order to stimulate prudent selection of health insurance by employees, employees may receive non-taxable rebates when choosing an insurance policy where the premium cost is less than the amount of the employer contribution.

7. *Quality of Care.*—Employer health insurance plans should assure employees the free choice of medical care services. Services should be of high quality. Plans should provide comparable benefits for treatment of physical and mental illness.

Senator **JEPSEN**. There is one word in our society that we would pick that is very key in regards to caring for people probably would be the word accessibility, the accessibility to medical care, accessibility to the institution. And you mentioned access and accessibility several times, it's frequent throughout your testimony.

In both the rural and urban areas my office has heard, doctor, from a number of Iowa physicians who strongly object to the Iowa Foundation for Medical Care questioning admission practices. Is it your opinion that the majority of Iowa doctors welcome the oversite of the Foundation?

Dr. **SWANEY**. Yes, I think the Iowa Foundation for Medical Care has in general been quite just, and I think that some of the changes they brought about, some of the decreased utilization was definitely called for. I would have some reservation about what is going to happen with the new DRG system as far as some of that utilization. I think it may be going too far where it becomes a problem for patients, so time will have to tell that for us. We are just getting into it.

Senator **JEPSEN**. That's where I have heard a lot of complaints from, and there is a great need to work together in that area to resolve that.

Mr. Wallace or Samuel Wallace, president, St. Luke's Hospital, Cedar Rapids.

STATEMENT OF SAMUEL T. WALLACE, PRESIDENT, ST. LUKE'S HOSPITAL, CEDAR RAPIDS, IA

Mr. **WALLACE**. Thank you. I appreciate this opportunity to be able to speak to you on behalf of the urban hospitals, recognizing that we have both greater opportunities and in some respects even greater challenges than either the rural or public hospitals. Looked upon with pride as centers of community health provision and education, they are often among the larger employers as are many rural hospitals as a major labor intensive industry.

But unlike our counterparts in other areas of business and industry, the public expectation goes beyond the optional purchase of goods or services to that which touches the very core of human existence, our health care. Yet we must, like all other businesses, match the revenue to the expenses or in other words survive! That simple but expedient principle has become increasingly difficult to accomplish. With Government-imposed focused review and the serious limitations on admissions, shorter lengths of stay, and forced outpatient care, entire inpatient units in some hospitals and indeed some whole hospitals, even larger ones, have been closing for lack of volume and their specialty nature at the very least diluted by mixing services on other units.

It is acknowledged that hospitals had few incentives to efficiency under the former cost-plus system of reimbursement other than the conservative integrity of their boards to save. But a squeeze such as the 2.4 percent slash in DRG reimbursement for the second year of DRG at the 50 percent level recently announced by Health and Human Services is too much.

The threat thus becomes one that exceeds cost and extends to values. How far can a private community hospital such as St. Luke's stretch its ingenuity to avoid the ultimate drop in quality? At some point the diminishing pool of funds under budget neutrality are break-even and an increasing aging population that you heard about previously will erode the ethics of the system. That is, unless sufficient support systems can be developed linking private initiatives with Government programs.

One recent example of Government assistance to a privately supported service bears mention We are very happy and sincerely appreciative of the efforts of you, Senator Jepsen, and your staff in locating scarce replacement parts for the Lifeguard helicopter. Extending the usefulness of this lifesaving service is one way in which the Cedar Rapids hospitals can help fulfill their rightful obligations to the rural areas of eastern Iowa.

It is, in our opinion, only one way in which urban hospitals can help maintain optimal health services to our smaller communities, so necessary to the preservation of the agricultural eonomy in Iowa. A recent study conducted by Donald Cordes under the sponsorship of the Health Policy Corp. of Iowa revealed that physicians were not likely to locate in rural areas without the backup of a hospital within 10 miles. Currently few citizens in Iowa live in excess of 10 miles from a physician. But with dire predictions about the survival of small hospitals, it is urgent that there be a supportive urban/rural network to enable small hospitals to share costly technology, material, and managerial resources and to provide a specialty outreach. Such a network now exists with the voluntary hospitals of Iowa about which you will hear later. It links the resources of the urban hospitals with that of the rural sector in a unified system which preserves the individual hospital's autonomy.

We would like to see such private initiatives, of which this is but one example, recognized by Government as a way in which cost containment is being accomplished without dependency upon the Government.

It is also our belief that hospitals will need to more fully compromise and cooperate, that with lower volume of patients, quality will suffer unless that occurs—but the Federal Government has not made that easy! Some Federal antitrust laws themselves have obstructed or delayed such efforts out of fear of reprisals such as triple damages and jail sentences. While most take a philosophic position on this dilemma, it would well serve the Nation's hospitals for the Government to modify their approach and encourage greater efforts to avoid duplication of services.

The points I tried to make are these: Cost containment is relative to American values. Under current Government constraints, the urban hospital is finding it more difficult to maintain the high standards and range of services necessary to those values.

Regional planning is a must to preserve and link the health care of rural and urban constituencies and one important solution to reduce costs. The momentum is building for cost containment. Let it survive! Thank you.

Senator **Jepsen**. Thank you, Sam. The 2.4-percent slash is being reexamined, as you may know, as a result of congressional objections and there should be some new figures out fairly soon on that.

Now, the more rural oriented hospitals. Sara B. Miller, administrator of the Anamosa Community Hospital, or is it Sally?

Ms. **Sara** B. **Miller**. Well, it's both. Sally is the nickname.

Senator **Jepsen**. Sally is the nickname, Sara is the correct name; I am right on both counts?

Ms. **Sara** B. **Miller**. You are.

Senator **Jepsen**. I was impressed, as I had a chance to review briefly the various sections of your testimony, on the depth you went to in getting ready for this report. I am looking forward to it. You contacted a lot of hospitals in Iowa.

Ms. **Sara** B. **Miller**. Yes.

Senator **Jepsen**. You may proceed.

STATEMENT OF SARA B. MILLER, ADMINISTRATOR, ANAMOSA COMMUNITY HOSPITAL, ANAMOSA, IA

Ms. **Sara** B. **Miller**. To effectively evaluate the current trends in rural health care providers and services, we are compelled to look at not only the apparent trends, but also the causes and the effects of the rural specific dilemmas before us.

To accurately share the rural health care position with this group, 46 hospitals under 50 beds in Iowa were contacted. Every available administrator was asked "If you had the opportunity to share your major concerns regarding rural health care and the changing role of your hospital, what would you say?" After compiling the results, it is clear that the primary rural health care and institutions, the community hospitals, have a statement: The trend, if the health care process continues on its current course, is not only a decreased utilization of rural hospitals, but also the closing of many rural acute care institutions in our State.

Rural health care, hospitals under 50 beds, have been a significant social and economic factor in our small communities—often not only the health care provider, but also the No. 1 employer. Hospitals have been the center for community pride, programs and outreach. Historically, rural hospitals have provided care at lower rates than their urban counterpart. The community hospital has had a family life process focus—from birth to death, with many generations of the same family being served. This institution is in jeopardy. The quality and diversity of each and every one of the rural hospitals is at risk. It is the opinion of many rural health care providers that the current financial policies of our Government are the primary influence in the rural health care policies, that financial policies are indeed dictating health care trends to the extent that some hospitals may close.

The impact of the Prospective Payment System is clear in all health care institutions large or small. Its influence is certainly evident to all of us every day. However, the rural hospitals have several "rural specific" disadvantages that make the impact of the new Medicare reimbursement system overwhelming. First, proportionately there is a clustering of elderly in rural community hospitals. Urban centers often range from 25 to 30 percent Medicare patients. In Anamosa, not unlike other rural communities, the Medicare percentage averages above 60 percent. Obviously changes in Medicare reimbursement effect the financial statements of rural hospitals more dramatically than large hospitals.

Second, Medicare reimburses rural hospitals differently than urban hospitals. Although the system is the same, the actual reimbursement is substantially less. The labor component of each DRG in rural Iowa is 25 percent less than the urban labor component. The nonlabor rural component is 54 percent less than the same urban component. In the majority of the State of Iowa, the rural hospital is competing with the urban institution for labor. Although one might argue that the labor component should be less based on the less technical aspects of rural health care, there is no justifiable reason for such a drastically different non-labor component. These differentials are compounded when DRG per case reimbursement is calculated. 25 percent less labor component; 54 percent less nonlabor component.

These statistics graphically speak to the rural health care trends in diminished reimbursement for our hospitals.

Third, there are several other inequities in Medicare reimbursement for the rural hospital. For example, the rural hospital has traditionally been the transferring institution for advanced care and support. Under the Prospective Pricing System, the transferring hospital loses substantial dollars in transfer. It would appear that several hospitals are losing $1,000 in actual cost each time they transfer a cardiac patient. It would seem that rural hospitals are being penalized for doing their job.

Indeed, most rural hospitals have the opinion that the Health Care Financing Administration would like to see them close. Correct or incorrect, this impression is given to small hospitals. It is a sad statement reflecting health care trends. The reimbursement figures are changing more quickly than budgets can be adjusted. The 2.4 percent decrease in reimbursement has only served to reinforce all the concerns over the PPS; it is held up as the example of negative change over which the rural hospital has no control, but under which it must function. The fiscal integrity of HCFA becomes more questionable to rural health care administration with each change in the reimbursement mechanism.

There are many positive trends in rural health care—toward education, home health programs, volunteerism and renewed community activities. However, these trends will stop if we lose our rural hospitals. There will be no hospital-based wellness programs, no hospital-based home health plans, no new health care services, no mobile or shared services, no patient education programs, no community cardiac rehabilitation, no rural prenatal classes, no new physicians, and very few full service emergency care centers. We will have allowed the focus of our health care to be dictated by incomplete reimbursement programs that do not fully or adequately address rural health care needs. Rural health care providers and consumers must begin now to create a survival health care atmosphere for the physical and social well-being of rural Iowa. Thank you.

Senator JEPSEN. Thank you, Sally. Does your hospital participate in the so-called swing bed program?

Ms. SARA B. MILLER. Yes.

Senator JEPSEN. As you know the Governor's Committee on Rural Health Care designed the swing bed program as one of the ways to help rural hospitals to meet the needs of the community. However, some of the nursing homes question the need for such a program.

Would you favor requiring a hospital to obtain a certificate of need as a precondition for participating in the program? Or do you want to submit that answer in writing later on?

Ms. SARA B. MILLER. I guess I would not favor certificates of need. I think in the rural setting that we have to realistically look at what swing beds mean and define that, and if we are going to be in a long-term facility role, we need to admit that, say that's what we are doing. It isn't a good health care practice to be competing and not admitting it and dealing with what kind of care you are doing. Acute care is different than long-term care.

Senator JEPSEN. What's your position on the prospective payment system? Can it best be described as strongly opposed, mildly opposed or supportive as long as changes were made in the urban-rural distinction?

Ms. SARA B. MILLER. I would say strongly support the change in the system.

Senator JEPSEN. If it was changed, you strongly support the system?

Ms. SARA B. MILLER. I strongly support the system anyway. I would like to see it changed for the benefit of the rural hospitals, yes.

Senator JEPSEN. Thank you. Mr. Levitz, assistant director, University of Iowa Hospital and Clinic. You may proceed, sir.

STATEMENT OF GARY S. LEVITZ, ASSISTANT TO THE DIRECTOR, UNIVERSITY OF IOWA HOSPITALS AND CLINICS, CEDAR RAPIDS, IA, PRESENTED ON BEHALF OF JOHN W. COLLOTON, DIRECTOR OF UNIVERSITY OF IOWA HOSPITALS AND CLINICS AND ASSISTANT TO THE UNIVERSITY PRESIDENT FOR STATEWIDE HEALTH SERVICES

Mr. LEVITZ. Thank you very much, Senator Jepsen.

Because of a previous commitment for this afternoon, John Colloton, director at University Hospitals, cannot be here for this hearing. He does share with you and those who are here today a concern that the current focus on the costs of health care does not overshadow our desire to assure access to quality health care for all our citizens.

You ask "How are we solving the problems of cost, access, and quality?" I applaud you for your consideration of the interrelationship among these elements. However, there has been an intensification in the debate over how best to control what many believe to be alarming growth in health care spending, without appropriate attention to the impact of proposals on access and quality of health care provided. In this context, the important role played by the academic health center, the teaching hospital, must be addressed.

The newly enacted Medicare legislation establishing a system of paying hospitals at a prospectively determined fixed price based on the classification into diagnosis related groups or DRG's is a major effort by the Federal Government to control its health care costs and will have a major impact on hospitals across the country, with serious implications for teaching hospitals and academic health centers in particular, as I will now discuss.

Studies on the impact of the Prospective Payment System will be conducted by Health Care Financing Administration and the Prospective Payment Assessment Commission, a 15 member nationally represented body. In Iowa, we are fortunate, that John Colloton is a member of this commission. There are a number of concerns that should be specifically addressed as these studies are performed and reported.

The first of these concerns is for the recognition of teaching hospitals' societal contributions. Colleges of medicine and teaching hospitals are the producers of multiple products that benefit not only the individual patient, but society as a whole. These products include medical and other health science education, new technology testing, clinical research, substantial amounts of charity care, highly specialized services, and extensive ambulatory care programs, usually operating on a subsidized basis. Generation of these multiple products which are termed "societal contributions," necessarily results in higher costs that must be reflected in teaching hospital patient charges. Obviously, the teaching hospital payments under the DRG system, if they are to be equitable to sustain generation of the societal contributions, must be differentiated from those paid to a community hospital which does not incur these costs. Fortunately, this need, to a certain extent, has been recognized by Congress through the direct educational cost "pass-through" and the indirect educational cost factor adjustment.

Even though the higher costs experienced by teaching institutions in providing a broad array of societal goods are recognized by the indirect educational cost allowance, we believe that the continuity of this educational cost adjustment is in potential jeopardy because it is out in the open without a solid formula to continue justification of its existence. Without the indirect educational cost adjustment and continued participation by the Medicare Program in payment for educational programs, teaching hospitals would have major difficulty in maintaining highly sophisticated patient services and teaching programs for the training of residents and the replenishment of health personnel essential to the staffing of our community delivery systems in future years in order to assure accessibility of our citizens to quality health care services.

At the present time, the DRG's, themselves, do not contain an adjustment for severity of illness. This is another concern. This problem is addressed through proxy by the indirect educational cost adjustment. It is expected that teaching hospitals treat a patient case mix containing a high volume of more severely ill rather than less severely ill patients within DRG's and these hospitals will face great difficulty without some kind of adjustment for the severity of these patients. Leaders in academic health centers and university teaching hospitals are appreciative of the congressional recognition of the severity of illness issue as part of the indirect educational cost adjustment and believe this adjustment must be maintained until a severity of illness adjustment is incorporated into the DRG system.

Another concern focuses on the continued support for technology growth. The Medicare Program has allowed only 1 percent adjustment for new technology under TEFRA, and beginning on October 1, 1986, any new technology incurred or acquired by a hospital must be covered in the DRG rates. With this major downward adjustment in payment for new technology, Government has begun to limit the future growth and development of the health care system. While I am in agreement that unnecessary duplication of services should be avoided, caution is advised in applying an arbitrary standard in an effort to reduce duplication that may also thwart technological advances which will ultimately benefit our citizens.

The proposed rules on the second Medicare prospective payment year published in the July 3, 1984 Federal Register describe several potential changes in the reimbursement system.

The proposed rules recommend that the outlier criteria be increased and outlier payments decreased. I strongly oppose HCFA's proposal to increase outlier thresholds and reduce the percentage of outlier payments after less than one year's experience. The diagnosis related groups are a patient classification system containing only 467 categories. As a result, much of the information on the clinical needs of the individual patient is lost. Outlier payments need to be maintained at their current level throughout the phase-in period in order to adequately compensate hospitals for atypically expensive long stay patients.

HCFA plans to reduce case mix weights by 2.4 percent on the assumption that increasing case mix intensity is solely the result of improved coding. Along with Sam Wallace, I strongly recommend that the case mix weights be retained at their original values until a comprehensive and objective assessment of the DRG weights has been conducted.

HCFA's proposal to allow cost outlier payments to transferring hospitals is desirable. Present policy prohibits outlier payments to the transferring hospitals for patients who are day outliers or cost outliers. The transferring hospital should be allowed to receive cost outlier payments.

Before us lies the complex problem of health care financing which calls for the adoption of a long range strategy which should be the result of consultative study. The Medicare program is but one element in the medical care marketplace, and any reforms adopted for Medicare must take into account the relationships among the other diverse components involved.

At the national level, there is a need for an equitable financing mechanism for health care that guarantees access to quality health services for all Americans and the maintenance of our teaching and patient care initiatives. The real problem before us today is to establish a framework through which we may collectively develop an effective and efficient mechanism to plan, provide, and pay for health services and educational programs. The prime responsibility for the leadership essential to the establishment of such a Federal policy rests with the executive branch and the Congress. A national policy on health care financing reform is long overdue and critically needed to lend direction, unity, and success to this system.

In conclusion, Senator, the establishment of a basic principle that calls for all players to pay their proportionate fair share of the costs of caring for the poor and aged until a national policy is enacted is critically needed, at this juncture.

Thank you for the opportunity to speak today.

Senator JEPSEN. Thank you for your testimony. Do you feel that the financial responsibility, to quote you in your conclusion, "for health care that guarantees access to quality health services for all Americans and maintenance of our teaching and patient care initiatives," would primarily come from the Federal level?

Mr. LEVITZ. The responsibility for the leadership clearly. However, as you are aware, you mentioned in your opening statement, the health system itself is complex, and interests of the provider, the interests of the insureds, business, labor, management, the consumer needs to be considered, and each one is equally responsible and each one participates equally in both the problems of the system but also in the strengths of developing the system to a point now where it's recognized as the best medical system in the world. Leadership should come from the executive branch, from Congress, with input from other groups as needed.

Senator JEPSEN. So your response was that leadership should come to seek to find these answers, but you are not saying that financing should come from there just without study and so on. So people do, and I am a little confused here with your statement. You say there is a need for an equitable financing mechanism.

Mr. LEVITZ. There is a need to assure that the financial needs of hospitals, of academic health centers are met. As part of this need it's important that all payers, of which the Federal Government is one, provide their fair share of the costs of providing care in the community.

Senator JEPSEN. Just curious now, another question: What is the Federal Government's fair share and what's the State government's fair share, what's the local government's fair share?

Mr. LEVITZ. Well, at the current time the DRG system and the Medicare cost reporting principles, plus the recognition on the part of other payers that health care costs have been increasing, what's been happening is that each payer has been trying to accomplish the best rate possible with a provider or group of providers, not necessarily recognizing the costs of poviding care for other people, like the costs of charity care in the community, the costs of teaching programs.

What we are proposing, we recommend that you consider, are ways in which these costs are recognized or funded in a way that assures the stability of these hospitals, while at the same time allowing them to be competitive on a cost basis with other providers. We do recognize the need to keep health care costs down. We do recognize the need to assure that health care is provided in the most efficient way possible and at the best dollar value. On the other hand, all payers should recognize the need to fund the contributions that academic health centers and community hospitals make.

Senator **Jepsen**. I thank you. Jim Tinker, administrator, Mercy Hospital, Cedar Rapids. You may proceed.

STATEMENT OF JIM TINKER, ADMINISTRATOR, MERCY HOSPITAL, CEDAR RAPIDS, IA

Mr. **Tinker**. Senator Jepsen, distinguished colleagues, I appreciate the invitation to be here and testify this afternoon. We have heard from the physician, statement from the urban hospital, rural hospital, research and teaching institution, and we will hear from the home health provider. I thought in the increasingly competitive marketplace we ought to have a word and somebody should say something about the interest of the patient.

Five days, let alone 5 minutes, is hardly time to provide you with the most rudimentary outline of what I consider to be profound implications for the delivery of health services and which I believe could very easily result from the current competitive, economic, political and simultaneously regulated climate that's facing hospitals in Iowa and across the country.

Let me state at first, that hospitals are responding to public and private, consumer and third-party payer, to business and Government pressure to control costs with a responsiveness that has frankly surprised most of us that provide care for our State's ill. While reducing costs is hardly bad, the speed and the direct results should not only surprise, but frighten, those who have asked us to do it.

I think what's being said is that providers respond to incentives and are willing to follow policy direction; that providers are really no different from other people and other institutions in society. And that while the new competitive market strategy will reduce costs, we better make sure that they are incentives to maintain quality features and values, as Mr. Levitz said, that has made the American health care system the finest in the world.

In spite of the plaudits, pied pipers and charlatans, health care is not a commodity to be bartered and traded in the open marketplace, and even if that were desired, it's not possible to sell standardized appendectomies, gall bladders, or cardiac catheterizations. It is neither desirable, nor morally responsible, to barter in the open marketplace with the health, indeed the very lives, of our young people, with the increasing higher proportion of elderly in the population, or with the rest of us who fall someplace in between. To do so would require transplanting Solomon into the bureaucracy, or elevating the care givers, the professional people, to positions that until now I think only God could assume.

The hospitals, and indeed the physicians, have listened to the concerns for cost containment, to the concerns of people for affordable health care, and acted to cut back expenses. Mercy Hospital's operating budget decreased for the first time since Medicare in 1965 was started by 7 percent last year. More than half of all surgical procedures that we perform—we are performing about the same number this year as last year—are now done on an outpatient basis. That's an increase from 1980 of about 17, 18 percent to just over 50 percent now.

We have, as have our counterparts in Cedar Rapids and across the State, reduced our staff, cut back on our training programs, and research related expenses, eliminated many of the intangible elements of care, and streamlined our operation in ways that no other so-called industry in the country has tried. We have done it with no small difficulty and with great misgivings for the loss of a personal, identifiable interest in our patients that make our local hospitals respected community resources.

May I suggest, therefore, Senator, that you begin to apprise yourself and your staff, and your respected colleagues in the Congress, of a mounting and palpable resistance to these actions among the recipients of health care.

One needs look no further than the editorial pages of our State's newspapers to see the outcry against those that casually treat the lives of employees and constituents with bureaucratic abandon, which I predict, just as surely as a kernel of corn pushes up through the soil, will blossom forth into open hostility and resentment.

We have, because we have entered a new era of medical competition, been forced to turn patients out of a hospital with a callousness which tears at the very caring fiber of those who know better—the doctors, the patients, the pharmacists, the nurses, the therapists. These actions save money, perhaps, but just as surely these actions breed contempt for the rulemakers. We have created expectations among older Americans for good quality health care and health services, for security and comfort, for trust, for faith. Now I think the dawning of disillusionment can only lead to darkness and discontent.

What are the implications, Senator, of regulations which, in an attempt to control costs, send elderly cataract patients home from the outpatient surgery facility in less than a day, with no consideration of who will provide that care when the elderly patient arrives at home, eyes bandaged? Or who will assist the elderly male who must find the bathroom at 4 a.m. when his prostate calls? What, Senator, for a program that will not pay for the most functionally useful way to repair cataracts, the intraoccular lens implant, if the patient is hospitalized, but will pay it if the elderly person is healthy enough to have 1 day surgery? The statement implicit in this policy is that only those that are healthy are entitled to the best care. That, Senator, is a value judgment I am glad that we in the provider sector don't have to make, and from all indications I think hospitals throughout the country are refusing to accept the blame for such policies.

Or, Senator, for payment policies that make it more lucrative to use yesterday's techniques for the repair of certain hip fractures, but financially unattractive to employ more sophisticated techniques such as joint replacement. The effect of such policy is that hospitals and physicians will be rewarded for repairing broken bodies, but we will be unable to continue to improve the quality of life for our elderly citizens.

And who authorized the Government programs, Senator, that require hospitals and physicians to heal computerized diagnoses and ignore the patient as a living, feeling human being? What of the elderly man admitted for treatment of a stroke and who, in the process of testing that accompanies every hospital admission, is diagnosed as also having a tumor of the bladder? Are you and your colleagues aware, Senator, that for that particular problem we have to send a patient home at least 1 day, or if we treat him for his bladder tumor we receive no pay? It's not easy to explain that sort of Orwellian logic to the family, the patient, the physician, or even myself.

Mercy Hospital has had less than 2 months' experience with the new DRG, diagnosis related group prospective payment system, but there have been already some noticeable changes, I expect desired by some, certainly feared by others. Length of stay in the hospital is decreasing. Physician resentment is increasing. Our staff—trained for many years to administered care by standards developed in a more caring era, and certainly one which cared more for medical excellence than the dollar—our staff is confused, Senator, and I would have to say, if I could use one word, distraught.

We know better than to do everything we have been told to do, and I believe that our patients know our actions are being directed from outside the hospital.

The implications of competition in the health marketplace are mixed. We can contain costs better if we add one hyphenated word before competition—cooperative. Cooperative-competition—a philosophy of competing in areas generally far removed from the bedside so the patient is not compromised but cooperating to avoid inappropriate utilization of expensive high technology and personnel.

As you listen to the testimony delivered today, I believe you will hear real and honest concerns for the changes emerging in the health delivery system in this region, in this State. I also believe you will see early indications that your constituency is becoming restless as a result of what they perceive as a lack of concern on the part of rulemakers.

The implications of the administration's competitive market strategy are clearly mixed. Will our system of health care become one in which only the wealthy can afford the best, the latest, most sophisticated care? Will our headlong rush to contain costs be at the expense of the poor, or as was recently reported in the Des Moines Register, at the expense of the medically inarticulate? Is it possible, in this era of financial imperatives that a two-tier system of health care will be created in which the wealthy and articulate consumer can demand and purchase care quite different from the poor or from the less articulate, or even from the average American citizen?

If I see hope, Senator, it's because I believe the health care pendulum has swung about as far as it can. I hope that a competitive marketplace will eventually return that pendulum to a more central position and to the values that distinguish health care in our society—a reverence for life, a compassion for human suffering, a concern for the ill and injured in a personal, identifiable manner, and for a health system that provides equal access to all Americans for good quality health care at affordable prices.

Thank you, Senator, for this opportunity to testify on behalf of the Sisters and patients of Mercy Hospital and the patients throughout Eastern Iowa. We feel strongly about the cost and quality tradeoffs we are being forced to make and I would be happy to speak to your full committee hearings with details and specific examples such as Jody and Julie and Jim provided in your earlier panel. Thank you.

Senator **Jepsen**. I thank you. I thank you for your candid report. That's what we need. Don't pull any punches. I also note that, as everyone has here, we talk about access, equal access, and you may well be called on to speak to the full committee hearings on this. I would recommend it.

Mr. **Tinker**. Appreciate it.

Senator **Jepsen**. Ms. Muenchow, executive director of the Public Health Nursing Association. Welcome, you may proceed.

STATEMENT OF JUDIE MUENCHOW, EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION, CEDAR RAPIDS, IA

Ms. **Muenchow**. The first thing I want to point out, we have changed our name to the Visiting Nurse Association.

The Visiting Nurse Association is a voluntary, nonprofit corporation. The services of the agency are available to all, based on need rather than ability to pay. The agency is supported by Linn County Health Center funds, United Way of East Central Iowa funds, and fees from patients which are based on actual costs. Some of the patient fees are from third party sources, sources such as Medicare, Medicaid, and private insurance. Having been a part of Medicare since its inception in 1966 the agency has grown up with the program.

Currently we are faced with a multitude of choices. Rising hospital costs have placed heavy emphasis on home health as a less costly alternative. Further, this emphasis has created additional regulations governing the provision of multidisciplinary home health services.

In order to fully grasp the comprehensive nature of home health care one needs to begin reviewing the process beginning with discharge planning. In theory, planning for discharge must begin at the time of admission. In fact, preadmission planning is perhaps the ideal way to insure smooth transition from one level of care to another. Knowledge of available resources within and without the institution is essential. Open communication between levels of care in necessary to insure regular evaluation of the planning process. Involvement of patient and family in the entire process is likewise a critical element for success.

Home health care by its nature relies heavily on well-trained providers who are available to persons in need. Collaborative relationships between physicians and provider organizations are imperative. The use of nurse practitioners in rural underserved areas is just beginning. Reimbursement for their services is still being discussed.

When I talk of home health services I am referring to the full gamut of possibilities: Nursing physical therapy, speech therapy, occupational therapy, medical social services, nutritional therapy, and durable medical equipment. Additionally there are pharmaceuticals, supplies, homemaker/home health aides, and chore services. As we know, not all of these services are reimbursed by third party payers. Currently the nonprofit and government sector through local tax and charity dollars provide some services to persons unabe to pay. There is a trend for hospital based agencies to secure local funds to also provide these "free" services to low income persons. For some time it has been evident that "Medicare only" providers are not able to continue operation without the infusion of other types of reimbursement. No matter what the auspice, voluntary nonprofit, government, private nonprofit, hospital or nursing home based, or proprietary, the frequent changes in regulations governing home health care affect us all.

One of the ways organizations can assure continuation of their services is to consider forms of joint ventures. The July issue of "Caring" magazine, a publication of the National Association for Home Care, addressed itself to hospital-home health relationships. The variety of authors looked at partnerships, separate corporations, mergers, contractual arrangements, etc. At the root of all articles was a concern over antitrust.

Generally, antitrust laws prohibit restraints on competition that are unreasonable. Some restraints, such as price fixing are viewed as anticompetitive and thus illegal. Courts often use a "rule of reason" analysis examining the purpose of the parties and the effect of the challenged practice to determine whether it actually places an unreasonable restraint on competition. A court may find that an illegal tying arrangement exists when a seller sues its market power in one product or services to force a buyer to purchase not only the item he wants but a second, separate item from the seller. Thus, exclusive referral contracts between home health agencies and hospitals may appear to the court to have an adverse effect on competition within their market area.

The recent Supreme Court decision in the *Jefferson Parish District No. 2* v. *Hyde* case held that an exclusive contract between a hospital and a group of anesthesiologists does not violate the antitrust laws. The East Jefferson Hospital had a contract with Roux and Associates, a professional medical corporation, requiring that all anesthesiological services for the hospital's patients be performed by that firm. Dr. Edwin G. Hyde, a board certified anesthesiologist with privileges at a nearby hospital, applied for admission to the medical staff of East Jefferson Hospital. His request was denied. He then claimed the exclusive contract violated antitrust laws. Through multiple appeals the case was finally heard by the Supreme Court. The Court reviewed the impact of the exclusive contract on two groups. The consumers of medical services and the providers of anethesiological services. The Court determined that no showing of an actual adverse effect on competition had been made, and that there was no antitrust liability on this ground.

The effect of the *Hyde* decision on home health agencies and hospitals negotiating the exclusive contracts is in both the area of tying arrangements analysis and the rule of reason analysis. It appears that inpatient hospital services and home health services would be treated as two legally distinguishable services for purposes of antitrust and analysis. A party attacking an exclusive arrangement between a hospital and a home health agency would have to show that the hospital has substantial market power in the provision of inpatient services and that the hospital uses the market power to coerce patients to obtain home health services from the designated agency. A hospital and home health agency contemplating an exclusive contract also need to consider whether the contract will create an unreasonable restraint on competition under the rule of reason standard. A party attacking the exclusive arrangement between a hospital and a home health agency must prove that the contract imposed an unreasonable restraint on trade.

In view of the *Hyde* decision it seems imperative that Congress consider legislation that will allow joint ventures to prevent spiralling home health costs and at the same time insure available services to persons entitled to and in need of such services. Thank you .

Senator **Jepsen**. I thank you. So I am clear on the effect on the Hyde decision, you say that it's presently affecting your plans to enter into a contractual arrangement with St. Luke's Hospital or could possibly affect the arrangements with St. Luke's?

Ms. **Muenchow**. There is that possibility. In Utah recently three different groups, a physical therapist who had a privately owned corporation, a hospital, and a home health agency, joined together to form a separate nonprofit corporation for the provision of home health services in their community. That was Salt Lake City, UT. Another group in that area has challenged that arrangement on an antitrust basis, saying that by those three groups joining together, they had taken the edge of the market because they are the larger. As a group together, three of them become the largest provider in that area. The case hasn't been through the court, so it hasn't been tested yet, but I think legislation is necessary. More in the area of looking at competition from the home health prospective, our futures look pretty bleak. In the small areas such as Iowa, with hospitals moving into the home health arena, it closes referral sources to us for one thing, and second, the only care that we end up with is long-term chronic.

We have already heard today currently there is no real payment for it in an way, and most elderly people do not have the funds to pay for the nurse to come on a regular basis or the physical therapist to come on a regular basis in long-term care. Medicare is one program, but people have needs who are not eligible for Medicare.

Senator **Jepsen**. Cooperation, cooperative, wasn't that your word, Ms. Muenchow?

Ms. **Muenchow**. I think cooperation is the answer.

Senator **Jepsen**. Anyone else on the panel have any comments on this or any other subject before we go to our next panel? Dr. Swaney?

Dr. **Swaney**. I may just add one more comment, answering your previous question. The question was: Is the Federal Government doing its fair share or where can the Federal Government do its share, that Mr. Levitz answered somewhat, and I am sure that the hospital administrator and nursing home administrator could answer it may be even better than I can, but I could tell you my one little narrow point of view. For instance, the new requirements for Medicare in our offices, we must decide whether we would be willing to accept assignments or not, and there will be certain problems for us if we do not. Our name won't be listed in the book, our patients presumably will be looking for some other doctors who is listed in the book who will accept assignments. Now, in our office we have done some checking on what this assignment will involve. An office call is say $18 in our office. This year our overhead has been increasing every year because we aren't increasing fees and of course our expenses are increasing, so our overhead is somewhere around 47 percent. Medicare alone will pay something over $9 for an office call is what they have been paying in Linn County, we checked. And if the patient pays for this extra insurance, it's something like $12, and fewer and fewer are heading for that extra insurance now because they won't see a need for it and it's quite expensive for them. So what's happening is either you don't accept Medicare patients any more, and I am hearing my colleagues talk along these lines, or you don't accept assignment and charge them the usual.

And then you are going to be in the other problems that I mentioned, the sanctions that the Government is going to be enforcing against those who do not accept assignments. Or you end up right now maybe just breaking even, and maybe going in the hole very shortly. It's a dilemma. And I think that the hospitals and the nursing homes have seen this also. They are charging other people who pay, who have private insurance and whatever, enough to make up for what they are losing in the Medicare people.

Senator JEPSEN. It is a problem. Medicare which not too many years ago was brought into being was projected to cost $7 billion by 1990. It was $77 billion in 1982 and going straight up. So we all need to address it and work on it together. And I sense the feeling of both frustration and might just add of disgust with the bureaucracy under the rules in several statements here. I share that. But there are those who would listen to everything that was said this afternoon and more, and would say, well, the only way to do it is just for the Government to take it over, so they don't have to ask all these people whether they should have cooperation, just make them all cooperate. My guess is that's probably not something that's shared by any member of this panel.

Mr. TINKER. No. Could I just comment on that? One of the concerns is that not that he go one way or the other, he is sort of schizophrenic, we don't have a coherent policy or direction. On the one hand we are turning out more physicians. We have funded mega dollars to help manpower education. Then we come back and put regulations and controls on the primary care physician, the guy we are supposed to send out to do good. In the hospitals we are trying to figure out if we are going to have the control on the swing bed and the same time trying to force a competitive market. We are going to have the same thing as the neighborhood schools—hospitals with the empty beds. Would it make more sense to convert that into alternatives for adult living, whether it's apartments, condo's, swing beds, or some kind of residential care? And until we get some signals, just like I was saying, we will respond to the incentives, but we would like to have them there a little clearer, more distinct, and we would like to rely on them more than 1 or 2 or 3 years. We would like to have them changed or modified and go off in a direction that's there for 5, 10 years.

Senator JEPSEN. If we send the signals to Washington, will they fly OK in Cedar Rapids and play well in Butte, MT at the same time? Or do you think Cedar Rapids, everybody around this table, ought to speak out, bring in Anamosa, see what you can do about the thing you just mentioned.

I am not lecturing, just put it in the record.

Mr. **Tinker**. I would like to see a Federal policy.

Senator **Jepsen**. But I think it's a root, it's a bottom line. Are we going to have it centralized in Washington, do you want them to go ahead and take this over, or do we look at what's happening in Iowa, and Iowa leads the way in a lot of things. DRG has got some problems but at least we are moving.

Mr. **Tinker**. The Provinces of Canada have a national health plan, and there are certain characteristics of affordability, coverage, and various features, but it's administered and handled at the proper level. If you go to Winipeg, the overall framework is set up from Ottawa, but it's administered locally. They take care of the Indian population to the north and the well-to-do in Winipeg.

Senator **Jepsen**. Working pretty well.

Mr. **Tinker**. It seems to me we could learn some lessons from the north. I think the controls are designed to be local with some overall umbrella instruction.

Senator **Jepsen**. Now, we are coming. OK. I wish we had a couple of days.

Dr. **Swaney**. I think some of the frustrations right now, at least on the providers' part, is that Washington has implied that they were taking over in the care of the elderly and it really hasn't worked out that way. I think the people have been dupped a little bit that way.

Mr. **Levitz**. As one of the speakers mentioned earlier, the out-of-pocket costs for the elderly, even in the presence of the Medicare program, and supplemental insurance program, have been increasing. So at the same time you are talking and considering cutting back on the Medicare program in order to maintain access to quality health care services, you need to be conscious of the fact that the elderly already are bearing a significant part of the costs of the health care that they are purchasing for themselves.

Senator **Jepsen**. How much should—how much is enough?

Mr. **Levitz**. That's a question between the individual and the physician in attempting to provide the best care for the patient should not be—the decision on the type of care that the patient receives should not be made based on cost consideration. Except to the exclusion of alternatives. Now, to the extent that perhaps a less costly procedure can replace a costly procedure, yield the same result, then, yes in that way cost can be used, but cost being used so that an individual needs to decide whether or not to receive health care or another basic service or basic human need, I think that for our elderly, for our poor people, for all citizens we should find a way to make sure that those types of decisions aren't made. In answer how much, we need to insure access in the first place, then the content of the health care itself should be decided by the medical system, physicians and in consultation with other health professionals and the patient, and cost should not be a consideration. The physician should not be concerned with whether or not the patient, he or she, is being reimbursed by medicare, medicaid, Blue Cross, or has no insurance or third party payment at all.

Senator **Jepsen**. Well, we know that—I was asking Bill here, what role did the Federal Government play in the development of this helicopter ambulance here. I understand that's a local project, isn't it?

Mr. WALLACE. Yes; the lifeguard helicopter is local, although the city government actually owns the helicopter and we raised money for it and so forth and had a lot of help around from you and others.

Senator JEPSEN. I am not bringing it up for that reason, but was that——

Mr. WALLACE. Private initiative, cooperation between local government, civil defense——

Senator JEPSEN. Everybody got together here and moved mountains and got it done.

Mr. WALLACE. Right. Now we need to move some more mountains and get another one.

Senator JEPSEN. That can be done, too. Thank you very much. We will now go to the cost implications and funding sources, public funding—Madge Phillips, Brice Oakley, Jackie Hegwood, Joe Tilghman, John Weber, James Snyder. Welcome, and I would advise the panel—it's repetition—that your prepared statements will be introduced into the record. Therefore, you may summarize or proceed in any manner you so desire. You may proceed, and we will start with Madge Phillips, director of the Linn County Health Center. Welcome. You may proceed.

STATEMENT OF MADGE PHILLIPS, DIRECTOR, LINN COUNTY HEALTH CENTER, CEDAR RAPIDS, IA

Ms. PHILLIPS. Thank you, Senator Jepsen. I want to speak this afternoon, we have heard about the Federal Government's role in health care, regulatory as well as funding, and I want to speak specifically, I guess, to the funding role of the State of Iowa's funding of health care and of Linn County's funding of health care. The number of dollars—and when I started putting this together, I really hadn't realized this, but I do work with it, until I started putting it together what kind of dollars we were taking about. The number of dollars expended for public sources, that is State and county sources, for the provision of health care in Iowa and Linn County is truly staggering. We look at the State Department of Human Services as one of our mega agencies that has probably the largest budget, and then we realize that out of the $378 million budget for the Department of Human Services, 56.9 percent of that budget is allocated to Medicaid or health-related services. Let me review how this breaks down a little. The fiscal year 1985 budget for the Department of Human Services, which as I said is in excess of $378,000,000, the Medicaid State dollars are $134,350,000, 35.5 percent of the total department budget. You add to that Federal dollars in the amount of $184,975,000, and other dollars, $7 million, $7½ million, approximately, and you have a total then from the State of $326,774,000.

In addition to that, the State of Iowa supports four mental health institutes and the State dollars that go into those State mental health institutes, $30,373,000 plus, or 8 percent of the total Department of Human Services' budget. You add 60.649 Federal dollars, about 376,000 other dollars, and you have got $30,800,000 in the four mental health institutes. Then the State of Iowa supports two mental retardation hospital schools, and of those the State dollars there, $47,400,000 or 12.5 percent of the total Department of Human Services budget.

There are not so many Federal dollars and other dollars in this particular discipline for some reason, but you still have a total budget for the mental retardation schools of $47,751,000. Iowa is a small State.

Then in addition we have a community mental health/mental retardation funding from the Department of Human Services which is another $3,360,000, so if you add those up, the State dollars there, you have the $378,000,000.

Now, despite the magnitude of these dollars, we still see them as being very tight. For this year for the first time Iowa has been able to institute under Senator Bruner's leadership $2.4 million for a new medically needy program. But that $2.4 million is seen as only being able to serve the medically needy for a 6-month period and the population that's been served is very limited. It's mostly infants and children, those people—women who fall just over the AFDC or title XIX levels. It's a marvelous program, but it doesn't look like the $2.4 million is going to go all that far, and it certainly is a limited population to serve the medically needy.

On the Medicaid Program in the month of May for 1984, in Linn County we had a Medicaid eligible population of 10,060 persons in Linn County of which 5,636 individuals were served for 1 monthly expenditure in Linn County of $1,104,147 for Medicaid payments. So if one assumes this was an average monthly expenditure, you would be looking at an annual expenditure in Linn County of Medicaid dollars of better than $13,000,000. Medicaid impacts the total health delivery system, covers a multitude of services, which I am sure you are familiar with, including physicians, dentists, prescription drugs, hospitals, chiropractors, optometrists, opticians, ambulance services, transportation, hearing aids, podiatrists, occupational and physical therapists, home health agencies, medical equipment, psychologists, social workers, family planning, lab work, and orthopedic shoes, so we do pretty much cover the waterfront with that.

It's not our intent in this report to comment on the quality of the services received for these dollars, or for the availability of access, again Senator, access to medical providers for the medicaid patients.

In county tax dollars, and this is in addition to the $13 million that comes from the State into Linn County for Medicare costs, Linn County spends an additional amount of nearly $6 million for health services per year. This is $5,957,214. I have broken then county expenses into two general categories, one mental health and mental retardation, and the other medical and preventive services for patient or clients categories' that are other than mental health and mental retardation.

And in fiscal year 1984, $5 million were spent on mental health, mental retardation services and $911,528 were spent on other medical and preventive services.

In addition. Linn County through the Linn County Health Center funds the Visiting Nurses Association, the director spoke to you just recently, in the amount of $211.285 tax dollars with an additional $3.000 being subcontracted to VNA from the State Department of Health for home health aides. And I am not including some peripheral services that we do fund here such as homemakers and such services as in-home services for the elderly. I have tried to stick mostly to just more direct costs. The health center also funds the Children's Dental Health Center in St. Luke's Hospital in the amount of $47,000.

These support figures total $6,248,000 health dollars expended by Linn County, and then you add your $30 million from Medicaid, you are looking at health service dollars in Linn County at an estimated $19½ million. Because we have spoke, we have spoken about Iowa being a little different and doing its own thing, and because we have also talked about the need for cooperative ventures, particularly between the public and the private sectors, I would like to tell you in closing about a program that we have here in Linn County, and I know that Mr. Grahek is going to be speaking later on, I think it was Mr. Grahek who chaired the committee who said we need a program for the medically needy about 5 years ago and we started the medically needy program at the Linn County Health Center. This program covers outpatient services, not inpatient services because we can't afford them, for general care physicians and specialty physicians, for prescription drugs, x rays and laboratory costs. And in the last year this provided 3,540 patient visits to primary care physicians, 738 visits to specialty care physicians, 679 laboratory examinations, 362 x-ray examinations, and 10,294 prescriptions to 2,642 persons who were enrolled in the program and who were deemed medically needy.

To be medically needy you have to be in a very low income eligibility. They are primarily below $3,000 in cash income in a year and have absolutely no other kind of health coverage. No Medicare, no Medicaid, no title XIX, no Blue Cross, no Blue Shield, and so on. The process that we use here in Linn County is—and I want to say very proudly that every physician in Linn County participates and takes the patients who are referred by the Linn Health Services Program. The physicians' bills to Linn Health Services or the Linn County Health Center are 70 percent of their usual and customary fee and that is paid by county dollars within 30 days, and the other 30 percent is between the patient and the physician, and many of the physicians do forgive all or a part of that or it is a personal matter between the patient and the doctor.

In prescription drugs, the patient pays the first $2.25 as a deductible, and the rest is billed to Linn County and is paid again within 30 days with a minimum of paperwork. We do a number of—we do yearly physician and patient surveys and virtually everybody feels it's working very well. We are very pleased that there is that partnership between the private medical sector and the county in sharing for the medically needy.

Exclusive of administrative costs, which we try to keep very low, the dollars that we spent last year by the county on this program were $213,667, and I add that just because I thought you might be interested in one program that we happen to have in Linn County that I think we thought up ourselves.

And in closing, I would like to emphasize again that this report addresses itself only to the public dollars that are spent in Linn County and does not address itself to private third-party reimbursements, private individual payment, and the additional dollars for inpatient care that certainly magnify many times the dollars that are spent here on health care. Thank you very much.

Senator Jepsen. I thank you, Madge. Your medically needy program is most interesting, and if I understand you correctly, you said that you pay 70 percent, the doctors involved charge 70 percent of their basic customary charges, the recipients also pay the first $2.25 of their prescription.

Ms. PHILLIPS. Prescription drugs, and the 30 percent that's left, the physicians bill the county for 70 percent, then the 30 percent that's left is between the patient and the physician. I would like to add also that when—we limit our enrollment so we won't run out of money before the year is over. When the waiting list gets too long, as it does sometimes, the physicians will very kindly serve what we identify as crisis people on the waiting list at no charge until they can be moved onto the regular roles. So we have excellent, wonderful cooperation from the physician.

[The prepared statement of Ms. Phillips follows:]

PREPARED STATEMENT OF MADGE PHILLIPS

The number of dollars expended from public sources for the provision of health care in Iowa and in Linn County is truly staggering. Of the State Department of Human Services' budget for fiscal year 1985, 56.9 percent of the $378,148,968 is allocated for Medicaid or health related services. Let me review for you the following allocations.

The fiscal year 1985 budget for the Department of Human Services is $378,148,968. Of this, the following breakout occurs:

Medicaid

State dollars (35% of total DHS budget)	$134, 350, 000
Federal dollars	184, 975, 400
Other dollars	7, 449, 364
Total	326, 774, 764

Mental Health Institutes (4)

State dollars (8% of total DHS budget)	$30, 373, 015
Federal dollars	60, 649
Other dollars	376, 000
Total	30, 809, 664

Mental Retardation Schools (2)

State dollars (12.5% of total DHS budget)	$47, 400, 996
Federal dollars	150, 000
Other dollars	200, 822
Total	47, 751, 818

Community Mental Health/Mental Retardation Funds

State dollars (0.9% of total DHS budget)	$3, 360, 000
Federal dollars	0
Other dollars	0
Total	3, 360, 000

These are State dollars allocated statewide to health costs for fiscal year 1985. Despite the magnitude of these dollars, they are seen to be very tight. A new State allocation of 2.4 million for the medically needy is anticipated as being sufficient only for six months to a very limited population of women and children whose income falls just over the AFDC (Title XIX) levels.

On the Medicaid program in the month of May, 1984, Linn County had a Medicaid eligible population of 10,060 persons, of which 5,636 individuals were served for a month-of-May county expenditures of $1,104,147. If one assumes this is an average monthly expenditure and extends that amount for twelve months, Linn County's Medicaid expenditures would be an annual $13,249,764.

Medicaid impacts the total health delivery system and covers a multitude of services including those of physicians, dentists, prescription drugs, hospitals, chiropractors, optometrists, opticians, ambulance services, transportation, hearing aids, podiatrists, occupational and physical therapist, home health agencies, medical equipment, psychologists and social workers, family planning, lab work and orthopedic shoes.

It is not our intent in this report to comment on the quality of services received for these dollars, or for the availability of access to medical providers by Medicaid patients.

County Tax Dollars.—In addition to the County's $13 million in Medicare costs. Linn County spends an additional amount of $5,957,214 for health services. These County expenditures fall into two general categories: Mental Health/Mental Retardation; and medical and preventative services for patient/client categories other than mental health/mental retardation.

In fiscal year 1984, $5,045,686 was spent on mental health/mental retardation services; and $911,528 was spent on other medical and preventative services.

In addition, Linn County through the Linn County Health Center funds Visiting Nurses Association in the amount of $211,285 tax dollars with an additional $33,000 being subcontracted to VNA from a State Department of Health grant for home health aides. The Health Center also funds the Children's Dental Health Center in the amount of $47,066.00.

These support figures total $6,248,565 health dollars expended by Linn County. Adding Medicaid's $13,249,764 to the local tax dollars brings the public dollars spent for health services in Linn County to an estimated $19,498,329.

Included in the $911,528 spent by Linn County for medical and preventative services is $213,667.30 spent for outpatient medical care and prescription drugs for the County's "medically needy" population which does not qualify for assistance from any other source and has no private third-party assistance. This program, unique in Linn County, provided 3,540 patient visits to primary care physicians, 738 visits to specialty care physicians, 679 laboratory examinations, 362 X-ray examinations, and 10,294 prescriptions to 1,186 households out of an enrollment of 1,536 households (2,642 persons) enrolled in the programs in FY84. All Linn County physicians accept Linn Health Services patients. The physicians bill the county for 70 percent of their usual and customary fees, and the other 30 percent is between the patient and the doctor.

Prescription drugs are billed to the County with a $2.25 deduction per prescription paid by the patient. This program, a partnership of private and public health contributions to serve the medically needy population, is perceived through both provider and consumer satisfaction surveys to run very smoothly with a minimum of administrative costs and paperwork, and it answers a need remaining unmet by the very large amounts of monies spent from the public bodies for outpatient health care.

In closing, it should be noted that this report addresses itself only to the public health care monies spent in Linn County, and does not address itself to private third-party reimbursements or private individual payments.

Senator JEPSEN. Brice Oakley, chief counsel for Blue Cross-Blue Shield of Iowa. Welcome, Brice. Proceed. Again your prepared statement will be entered in the record. You may proceed in any manner you like.

STATEMENT OF BRICE OAKLEY, SENIOR ASSOCIATE COUNSEL, BLUE CROSS AND BLUE SHIELD OF IOWA, DES MOINES, IA

Mr. OAKLEY. Thank you Senator. I appreciate being here. My name is Brice Oakley, I am senior associate counsel and director of Public Relations for Blue Cross and Blue Shield of Iowa.

Our private, nonprofit organizations, along with our sister corporations—Delta Dental Plan of Iowa and the Iowa Pharmacy Service Corp.—provide comprehensive health care coverage for nearly 1 million Iowans. In addition, we also serve as one of the nation's most efficient cost-effective intermediaries on the Medicare A program as well as the carrier on Medicare part B in Iowa.

As I stated, we do appreciate this opportunity. Both in the interests of time, confining our remarks to 5 minutes, as well as I want to comment on the role the Government might most appropriately play. I am going to leave a substantial portion of our remarks for the record.

I do want to report to you, though, that we are pleased to tell you that as a result of concentrated cost containment programs, and a commitment to affordable health care coverage, that we have been able to reduce our rate or credit savings this year to nearly all of our subscribers, and I have a detailed report on this that has been previously furnished to your office, and if you would like it to be a part of the record, I would be pleased to do so.

This resulted from Blue Cross's strong utilization review program which was mandated in 1981, but it was also with the cooperation with the State's doctors and hospitals and citizens of the State; alterations in design of our benefits to encourage outpatient care whenever it was medically appropriate; and concentrated programs to alert Iowans to the cost savings possible through the judicious use of the health care system accrued to their benefit.

The price-oriented dynamic that is now driving the health care system has caused the pendulum to swing closer than ever before to just purely economic considerations. However, if we allow that pendulum to swing too far in that direction, we will be creating serious quality and access questions as have already been described to you.

As yet, in our judgment, the problems of access and quality have not reached the acute stage. The private sector has worked together with government to find some feasible solutions to our health care cost dilemma, but it is possible that we will face those problems which are plaguing other States if we neglect to view the health care system as a multi-faceted and truly complex entity.

I might add parenthetically that it's easy for the insurance industry, for example, to be only just cost conscious. In our judgment that's a short term view and does not reflect the industry. Employers do care about access and quality, they do care about their employees, and therefore we as an industry have to share those concerns with them with regard to quality and access.

To maintain a broad analysis of this and other crucial health care issues, our plans are going to commit more time to the analysis of Federal legislation impacting the health care industry. 1985. ERISA, Karen Ferguson, Kenneth Kephart, are all going to be part of that health care cost Lexicon in capital letters.

We appreciate the Senator's concern, for example, for the billing of private insurers for health care provided in military facilities in H.R. 5372. That was suggested by the Department of Defense without holding hearings. Clearly, further study is essential to the deliberation on that issue, which may have some far-reaching effects on private cost containment initiatives. And we appreciate your service as the chairman of that subcommittee in recognizing that further information had to be solicited on that before its consideration, though certainly it will be an issue next year.

I might also add that your background and expertise in insurance makes it easier to relate to some complex subjects. My learning curve has gone straight up in this business because I have been in it 1½ years, and, of course, you have been in it for many years and we appreciate your being sensitive to those issues.

As you know, though, the marketplaces in 1980 differ markedly from those of the previous 20 years. The focus has shifted dramatically to cost containment and a demand for prudent purchasing. The private sector's attention is concentrated intently on these problems, and indeed it's working hard to address a majority of them, but there is a role for Government.

We must recognize that Government wears two hats. It both finances the system; it's called upon also to provide leadership and to be the regulator of that system; and it has to choose carefully and recognize which hat it has on when it makes its policy decision, and whether they are purely in the fiscal area or whether they are truly reflecting overall leadership at the national level. For example, in keeping the competitive field equitable for all the competitors, by resisting the temptation to legislate it as important as legislating itself. Fixing the ERISA problem, which is changing a law that has already been passed; resisting all-payer arguments; avoiding measures which stifle the PPO development; opposing tax caps; and so forth. There are some issues, uncompensated care, the appropriate role of the Federal Government. It's a matter of leadership and national policy, perhaps also in the allocation of new capital. Both issues cannot perhaps be well taken care of in the private sector.

It's clear that our policies and those, and I say ours, that is the industry, in the private sector in general, have succeeded. We have improved the cost of care without any discernible sacrifice of quality. Industry inflation trends are slow. We are adopting alternatives to extensive inpatient care where appropriate. In the case of most of our subscribers the cost of the coverage is stabilizing or even falling. Iowa is leading the way and we are proud to be a part of that.

Think of the analogy to the energy field and what happened to energy in the 1970's. Health is the issue of the 1980's. And when Government overintervenes, when it became too much involved, it had to step back and repeal and adjust. Instead of trusting, one, the citizen as prudent buyer; second, trusting State government and the private industry itself, that's what happened in that field, and I would hope that we could avoid those mistakes.

In summary, the private sector indeed has a significant successful role to play in development which plague the industry. The continued success, however, requires an ongoing cooperation with the Government in some kind of a partnership. We, as the State's largest private health insurer are committed to a methodical but selective change which avoids a somewhat myopic concentration on the symptoms of the problem and instead considers the complex nature of the health care industry as a whole. Thank you.

[The prepared statement of Mr. Oakley follows:]

PREPARED STATEMENT OF BRICE OAKLEY

I am Brice Oakley, senior associate counsel for Blue Cross and Blue Shield of Iowa. Our private, non-profit organizations, along with our sister corporations—the Delta Dental Plan of Iowa and the Iowa Pharmacy Service Corporation—provide comprehensive health care coverage to nearly one million Iowans. In addition, we serve as one of the nation's most efficient and cost-effective intermediaries for the Medicare A program and as carrier for Medicare Part B in Iowa.

We appreciate the opportunity to comment on the role of private insurance in health care cost and access issues.

We're pleased to tell you that as a result of concentrated cost-containment programs and a solid commitment to affordable health care coverage, our organizations were able to reduce our rates or credit savings this year to nearly all of our subscribers.

This resulted from Blue Cross' strong utilization review program mandated in 1981 with the cooperation of the State's doctors, hospitals and citizens; alterations in the design of our benefits to encourage outpatient care whenever it is medically appropriate; and concentrated program to alert Iowans to the cost savings possible through the judicious use of the health care system and their own benefits.

These programs yielded a 20 percent decline in inpatient use for our subscribers in the past three and a half years. And the results we've seen are a tribute to all Iowans who readily adopted those cost-saving measures because these programs promoted quality health care in order to maintain an affordable cost.

Blue Cross and Blue Shield of Iowa have long served as a catalyst for health care cost initiatives and continue to explore and implement new measures for keeping care available and affordable.

Beginning late yast year, we implemented a revolutionary hospital prospective payment system which is fair to hospitals and patients alike, and which incorporate incentives for greater hospital efficiency and effectiveness in use without jeopardizing caliber of the health care provided in this state. It is a system which will serve as a model for other states because it was developed with the hospitals of Iowa—not as a unilateral effort which threatens their survival.

But there continues to be a widespread concern about the new Medicare payment system based on diagnosis related groups, particularly related to their potential negative impact on quality and access to health care. There is a great need to balance cost considerations with quality.

The price-oriented dynamic now driving the health care system has caused the pendulum to swing closer than ever before to economic considerations. However, if we allow that pendulum to swing too far in that direction, we will be creating serious quality and access problems.

As yet, the problems of access and quality have not reached the acute stage. The private sector has worked together with government to find feasible solutions to our health care cost dilemmas. But it is possible that we will face those problems which are plaguing other states if we neglect to view the health care system as a multi-faceted, complex entity.

To maintain a broad analysis of this and other crucial health care issues, our plans will commit more time to the analysis of federal legislation impacting the health care industry.

We appreciated the senator's concern for the billing of private insurers for health care provided in military facilities (H.R. 5372) without holding hearings. Clearly, further study is essential to deliberation of this issue, which may have far-reaching effects on private cost-containment initiatives.

As you know, the marketplace of the 1980's differs markedly from those in the previous twenty years. The focus has shifted dramatically to cost containment and a demand for "prudent purchasing." The private sector's attention is concentrated intently on these problems and indeed, its efforts will successfully address the majority of them.

However, there remains a crucial role for government on two fronts.

First, in keeping the competitive field equitable for all competitors; specifically, by fixing the ERISA problem; resisting all-payer arguments; avoiding measures which stifle PPO development; opposing tax caps; and by not promoting risk segmentation and adverse selection through artificial multiple-choice or voucher systems.

Then, government should address those issues such as uncompensated care and the allocation of new capital, which will not be addressed effectively through the competitive marketplace.

To expand for a moment on the issues of ERISA, we support amending this act so that it pre-empts state-mandated benefit laws, continuation conversion laws and provider freedom-of-choice laws insofar as those laws apply to insured employee health benefit plans. This will foster greater cost-containment possibilities for the private sector.

Blue Cross and Blue Shield of Iowa are committed to balancing the business community's natural advocacy for revolution in health care with both the providers' relative resistance to radical change in the health care industry and the government's need for planned predictability in its health care entitlement programs.

It is clear that our policies—and those of the private sector in general—have succeeded. We have improved the cost of care without discernible sacrifice of quality. The industry inflation trends are slowing. We are adopting alternatives to expensive inpatient care, where appropriate. And in the case of most of our subscribers, the cost of coverage is stabilizing or even falling. Iowa is leading the way, and we are proud to be a part of it.

In summary, the private sector indeed has a significant and successful role to play in the development of alternatives to the cost problems which plague today's health care industry.

Continued success, however, requires ongoing cooperation with government in a public-private partnership. We, as the State's largest private health insurer, are committed to methodical, selective change which avoids myopic concentration on the symptoms of the problem and instead, considers the complex nature of the health care industry as a whole.

Senator **Jepsen**. Thank you, Brice. Jackie Hegwood, Social Security Administration, Cedar Rapids office.

Jackie, you may proceed.

STATEMENT OF JACKIE HEGWOOD, OPERATIONS SUPERVISOR, SOCIAL SECURITY DISTRICT OFFICE, CEDAR RAPIDS, IA

Ms. **Hegwood**. Thank you, sir. I am from the Cedar Rapids Social Security District Office. I have been asked to give a brief explanation of the way the local Social Security office provides health care information to the public under the Medicare program.

The local office provides information on Medicare entitlement provisions and helps the public complete appropriate application forms to secure Medicare coverage. After initial entitlement has been established under Medicare, the office will provide assistance in completing the request for Medicare payment form and will provide general information on coverage of specific items. If more detailed information is required regarding items covered or if there is a question regarding a previously submitted claim for payment, the public is referred to the Medicare toll-free number in Des Moines. If there are questions about the payment received, the office will provide an explanation of the appeal procedure and assist the public in completing the appropriate forms.

The office makes available to the public various pamphlets, both general information pamphlets and ones which provide an indepth explanation of a specific aspect of Medicare coverage. The office has available to the public such listings as Directory of Medical Facilities, Directory of Nursing Homes, Directory of Providers of Kidney Dialysis and Transplant Services and Provider Assignment Rate Listings. The Social Security office makes every attempt to widely distribute information about the Medicare Program and to answer any questions the public might have on enrollment and coverage aspects of the program. The office is available to help in completing any forms needed under the Medicare Program and to provide any printed material the public might request in regard to Medicare.

Senator **Jepsen**. Thank you very much, Jackie. Joe Tilghman, deputy regional administrator, Health Care Financing Administration.

STATEMENT OF JOE TILGHMAN, DEPUTY REGIONAL ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, KANSAS CITY REGIONAL OFFICE, KANSAS CITY, MO

Mr. TILGHMAN. I am from Health Care Financing Administration regional office in Kansas City. We are responsible for the Federal administration of the Medicare and Medicaid Programs in a four-State area, those being Iowa, Kansas, Missouri, and Nebraska. Let me say before I get into my prepared statement, I have enjoyed being here today. I haven't always enjoyed what I heard said about the Medicare and Medicaid Programs, but I think it's very helpful to hear this type of exchange of thought about our programs and how they are working.

I also enjoyed meeting Julie Beckett today. I remember very well the night, it was all the way back in November 1981, it doesn't seem like it could be that long ago, I received a call at home. I didn't watch the news conference that night, but within 5 minutes when he mentioned Katie Beckett on the news conference, my home phone was ringing, and I spent probably the next 2 weeks or so immersed in Katie Beckett, doing everything we could working with the State people and county people and our central office people to get her out of the hospital and home, and I can assure her that she has very successfully synthetized the bureaucracy as far as not only Katie, but also with other cases like hers. We know what it's all about and we pay a lot of attention to them when they come across our desk these days.

I want to talk about three areas today. They are basic recent changes in the Medicare Program. Two of them have already been discussed to some extent. One is hospital prospective payment, the other one is reimbursement for physicians under part B of the Medicare Program, and the last one is how we are going to reimburse for laboratory services. I am going to use a prepared text on that cause they are complicated subjects and I think there is a lot of interest in them and I want to make sure I get all the points across that I think should be made.

Before I get into the prepared statement on these three areas, one point I would like to emphasize is that I have been with either the Medicare or Medicaid Program at the Federal level since July, 1971, and during that 13-year period we have never been as busy as an agency as we have in the last 3 years, and expect to be for the next year or 2 years or so, based on what we know is coming. There have been an awful lot of significant, complex, rapid changes made during that period. And we expect more to come shortly. The point I want to make is that there is a lot of interest at the Federal level and in Congress and may be changes, and there is a lot of activity underway right now that I think most of you are aware of. You may not like all of it; you may disagree with some of it, you may see need for some more changes, but there is a full agenda at the Federal level right now and we expect to have a lot more. With that I would like to go into those three points.

The Social Security Amendments of 1983 contained what is probably the most significant change to the Medicare Program since it was enacted in 1965. This change is the prospective payment system, commonly called PPS, also DRG's for hospitals. For the past 17 years, hospitals were reimbursed on the Medicare Program on a reasonable cost basis, a basis which failed to encourage efficiency since we reimbursed basically for whatever costs were incurred. Since October of 1983, Medicare prospective payments have been based on standardized rates keyed to the patient's diagnosis rather than on the previous open-ended cost-based system which was a dominant contributor to health care inflation.

We now establish, in advance, set rates for each of 468 Diagnosis Related Groups or DRG's—such as cataract, hip replacement, heart attacks, and other major procedures. These rates are based on the average amount of resources needed to take care of each type of case. Since the fixed rate is considered payment in full, hospitals are prohibited from charging beneficiaries more than the statutory deductible and coinsurance amounts. Prospective payment rewards hospitals that organize and provide care efficiently and forces those that are inefficient to absorb the cost of their inefficiency. Over the long run, PPS should prove to be a valuable weapon in our battle to control the rise in health care costs.

The full impact of this system will not be felt until its 3-year phase-in is complete. However, since it began last October 17, it has already had a beneficial effect. With a total of nearly 5,000 or three-fourths of all short-stay hospitals now on prospective payment, we have seen hospital admissions decrease slightly, about 1 percent from the corresponding period of the year before. In addition, the average length of stay in all hospitals has declined from 9.7 days to 9 days. This shorter length of stay is partly the result of PPS encouraging hospitals to provide services in an efficient manner.

Under this system, we continue our commitment to insure that high quality and appropriate medical care is maintained in the hospital setting. We rely on several mechanisms to achieve this end. These include Peer Review Organizations, Medicare contractors, and facility surveys. In every State, our contracts with Peer Review Organizations require them to achieve the following kinds of objectives: First, Reduction of readmissions that occur because the patient received care during a prior hospital stay; Second, Assurance that a patient received the kind of care needed to avoid serious complications; Third, Reduction of unnecessary surgery or invasive procedures; and fourth, Reduction of avoidable postoperative complications.

Our Medicare contractors, in Iowa it's Sioux City Blue Cross and Iowa Blue Cross-Blue Shield in Des Moines, upon whom we are also relying for the maintenance of high quality care, will continue to screen claims to assure that the care being billed for is covered and appropriately provided. And, finally, the third mechanism, facility surveys, ensures that the participating institution, i.e., the hospital, continues to meet standards necessary for its ongoing participation in Medicare. We are determined that through these three approaches high quality care will be maintained for Medicare beneficiaries.

The Deficit Reduction Act, which became Public Law 98-369 on July 18 of this year, made a number of changes to PPS. One modification will make it easier for certain rural hospitals to be more appropriately classified as regional referral centers and receive the urban rate of the PPS, which is higher. An additional change allows hospitals located in counties redesignated as rural to have a 2-year transition to the rural rates rather than to receive the lower rate immediately.

The Deficit Reduction Act also included two key provisions which will help control expenditures to the programs as well as to the millions of beneficiaries dependent on Medicare as a basic source of financial protection against the high cost of medical care.

Under one of these—this is the one Dr. Swaney mentioned earlier, made some comments—all physicians' fees paid for by Medicare will be frozen for a 15-month period beginning with July 1 of this year. Beginning with October 1, physicians will have the opportunity to agree to accept assignment for all services provided to Medicare patients during the coming year. Incentives for physician participation include the publication of directories of participating physicians which will be available at Social Security and carrier offices and at senior citizens' organizations. We will also inform Medicare beneficiaries of the publication of this directory. In addition, toll-free telephone lines will be maintained by carrier to disseminate this same information.

Nonparticipating physicians can continue to accept assignment on a case-by-case basis. However, in those instances where they choose not to accept assignment, they are forbidden to increase their charges to Medicare patients above their actual pattern of charges for the April through June 1982 quarter. If physicians fail to abide by this provision, this is for nonparticipating physicians, they can be subject to civil money penalties or to exclusion from the Medicare for up to 5 years or both. By freezing physicians' fees and by providing incentives for them to accept assignment for all services, we will be saving money for both the Medicare beneficiaries and the taxpayer.

The third area I have is payment for laboratory tests.

Prior to the District Reduction Act, the Medicare Program paid hospitals for outpatient laboratory services in much the same way that we formerly paid for inpatient services. That is, we essentially reimbursed laboratories on the basis of their costs. All other outpatient laboratory services, that is, those furnished by independent laboratories and physicians, were payed for on the basis of reasonable charges. These labs and physicians were also able to accept assignment on a case-by-case basis. With the enactment of Public Law 98–369, we now have the authority to establish fee schedules for outpatient laboratory services. By establishing these rates of payment in advance, we will also be encouraging the same efficient behavior in the provision of outpatient lab services that we are with inpatient hospital services. Furthermore, Public Law 98–369 also modified the assignment option so that now all independent and hospital labs are required to accept assignment, formerly only a requirement for hospital laboratories. In these cases, reimbursement at the fee schedule level will constitute full reimbursement. And no coinsurance or deductible will be required of the beneficiary. This offers protection to the beneficiary against rising out-of-pocket costs for the Medicare Program.

That concludes my testimony. I reemphasize the fact that I have only touched on three changes today. These seem to be the most important changes right now as far as public opinion at this time.

[The prepared statement of Mr. Tilghman follows:]

PREPARED STATEMENT OF JOE TILGHMAN

THANK YOU FOR THE OPPORTUNITY TO APPEAR HERE TODAY TO DISCUSS SOME OF THE RECENT MAJOR CHANGES TO THE MEDICARE PROGRAM. I WILL FOCUS SPECIFICALLY ON THREE REIMBURSEMENT CHANGES WHICH WE BELIEVE WILL HAVE A SIGNIFICANT POSITIVE EFFECT ON MEDICARE PROGRAM COSTS AND ON CONTROLLING THE OVERALL ESCALATION IN HEALTH CARE COSTS.

PROSPECTIVE PAYMENT

LAST APRIL, THE PRESIDENT SIGNED INTO LAW THE SOCIAL SECURITY AMENDMENTS OF 1983 (P.L. 98-21) WHICH CONTAINED WHAT IS PROBABLY THE MOST SIGNIFICANT CHANGE TO THE MEDICARE PROGRAM SINCE IT WAS ENACTED IN 1965. THIS CHANGE IS THE PROSPECTIVE PAYMENT SYSTEM (PPS) FOR HOSPITALS. FOR OVER 17 YEARS, HOSPITALS WERE REIMBURSED ON A REASONABLE COST BASIS WHICH FAILED TO ENCOURAGE EFFICIENCY SINCE WE REIMBURSED BASICALLY FOR WHATEVER COSTS WERE INCURRED. SINCE OCTOBER OF 1983, MEDICARE PROSPECTIVE PAYMENTS HAVE BEEN BASED ON STANDARDIZED RATES KEYED TO THE PATIENT'S DIAGNOSIS RATHER THAN ON THE PREVIOUS OPEN-ENDED COST-BASED SYSTEM WHICH WAS A DOMINANT CONTRIBUTOR TO HEALTH CARE INFLATION.

WE NOW ESTABLISH, IN ADVANCE, SET RATES FOR EACH OF 468 DIAGNOSIS RELATED GROUPS OR DRGS -- SUCH AS CATARACT, HIP REPLACEMENT, HEART ATTACKS, AND OTHER MAJOR PROCEDURES. THESE RATES ARE BASED ON THE AVERAGE AMOUNT OF RESOURCES NEEDED TO TAKE CARE OF EACH TYPE OF CASE. SINCE THE FIXED RATE IS CONSIDERED PAYMENT IN FULL, HOSPITALS ARE PROHIBITED FROM CHARGING BENEFICIARIES MORE THAN THE STATUTORY DEDUCTIBLE AND COINSURANCE. PROSPECTIVE PAYMENT REWARDS HOSPITALS THAT ORGANIZE AND PROVIDE CARE EFFICIENTLY AND FORCES THOSE THAT ARE INEFFICIENT TO ABSORB THE COST OF THEIR INEFFICIENCY. OVER THE LONG RUN, PPS SHOULD PROVE TO BE A VALUABLE WEAPON IN OUR BATTLE TO CONTROL THE RISE IN HEALTH CARE COSTS.

THE FULL IMPACT OF THIS SYSTEM WILL NOT BE FELT UNTIL ITS THREE-YEAR PHASE-IN IS COMPLETE, BUT SINCE IT BEGAN LAST OCTOBER IT HAS ALREADY HAD A BENEFICIAL EFFECT. WITH A TOTAL OF 4,967 OR 74 PERCENT OF ALL SHORT-STAY HOSPITALS NOW ON PROSPECTIVE PAYMENT, WE HAVE SEEN HOSPITAL ADMISSIONS DECREASE SLIGHTLY (ONE PERCENT) FROM THE CORRESPONDING PERIOD OF THE YEAR BEFORE. IN ADDITION, THE AVERAGE LENGTH OF STAY IN ALL HOSPITALS HAS DECLINED FROM 9.7 DAYS TO 9.0 DAYS. THIS SHORTER LENGTH OF STAY IS PARTLY THE RESULT OF OUR PROSPECTIVE PAYMENT SYSTEM WHICH ENCOURAGES HOSPITALS TO PROVIDE SERVICES TO OUR BENEFICIARIES IN AN EFFICIENT MANNER.

UNDER THIS NEW SYSTEM, WE CONTINUE OUR COMMITMENT TO ENSURING THAT HIGH QUALITY AND APPROPRIATE MEDICAL CARE IS MAINTAINED FOR THE MEDICARE POPULATION IN THE HOSPITAL SETTING. WE WILL BE RELYING ON SEVERAL MECHANISMS WHICH WE WILL CLOSELY MONITOR TO ACHIEVE THIS END. THESE INCLUDE PEER REVIEW ORGANIZATIONS, MEDICARE CONTRACTORS, AND FACILITY SURVEYS. IN EVERY STATE, OUR CONTRACTS WITH PEER REVIEW ORGANIZATIONS REQUIRE THEM TO ACHIEVE THE FOLLOWING KINDS OF OBJECTIVES: (1) REDUCTION OF READMISSIONS THAT OCCUR BECAUSE THE PATIENT RECEIVED SUBSTANDARD CARE DURING A PRIOR HOSPITAL STAY; (2) ASSURANCE THAT A PATIENT RECEIVED THE KIND OF CARE NEEDED TO AVOID SERIOUS COMPLICATIONS; (3) REDUCTION OF AVOIDABLE DEATHS; (4) REDUCTION OF UNNECESSARY SURGERY OR INVASIVE PROCEDURES; AND (5) REDUCTION OF AVOIDABLE POST-OPERATIVE COMPLICATIONS. OUR MEDICARE CONTRACTORS, UPON WHOM WE ARE ALSO RELYING FOR THE MAINTENANCE OF HIGH QUALITY CARE, WILL CONTINUE TO SCREEN CLAIMS TO ASSURE THAT THE CARE BEING BILLED FOR IS COVERED AND APPROPRIATELY

PROVIDED. AND, FINALLY, THE THIRD MECHANISM, FACILITY SURVEYS, ENSURES THAT THE PARTICIPATING INSTITUTION, I.E., THE HOSPITAL, CONTINUES TO MEET STANDARDS NECESSARY FOR ITS ONGOING PARTICIPATION IN MEDICARE. WE ARE DETERMINED THAT THROUGH THESE THREE APPROACHES HIGH QUALITY CARE WILL BE MAINTAINED.

THE DEFICIT REDUCTION ACT, WHICH BECAME LAW (P.L. 98-369) ON JULY 18 OF THIS YEAR, MADE A NUMBER OF CHANGES TO THE MEDICARE PROGRAM. AMONG THESE ARE SOME TECHNICAL AND OTHER MODIFICATIONS TO THE PROSPECTIVE PAYMENT SYSTEM. ONE MODIFICATION WILL MAKE IT EASIER FOR CERTAIN RURAL HOSPITALS TO BE MORE APPROPRIATELY CLASSIFIED AS REGIONAL REFERRAL CENTERS AND RECEIVE THE URBAN RATE, WHICH IS HIGHER. AN ADDITIONAL CHANGE ALLOWS HOSPITALS LOCATED IN COUNTIES REDESIGNATED AS RURAL TO HAVE A TWO-YEAR TRANSITION TO THE RURAL RATES RATHER THAN TO RECEIVE THE NEW (LOWER) RATE IMMEDIATELY.

PHYSICIAN REIMBURSEMENT

THE DEFICIT REDUCTION ACT ALSO INCLUDED TWO KEY PROVISIONS WHICH WILL HELP CONTROL EXPENDITURES TO THE PROGRAM AND TO THE MILLIONS OF BENEFICIARIES DEPENDENT ON MEDICARE AS A BASIC SOURCE OF FINANCIAL PROTECTION AGAINST THE HIGH COST OF MEDICAL CARE.

UNDER ONE OF THESE PROVISIONS, ALL PHYSICIANS' FEES PAID FOR BY MEDICARE WILL BE FROZEN FOR A 15-MONTH PERIOD, BEGINNING WITH JULY 1 OF THIS YEAR. BEGINNING WITH THIS OCTOBER 1, PHYSICIANS WILL HAVE THE OPPORTUNITY TO AGREE TO ACCEPT ASSIGNMENT FOR ALL SERVICES PROVIDED TO MEDICARE PATIENTS DURING THE COMING YEAR. INCENTIVES FOR

PHYSICIAN PARTICIPATION INCLUDE THE PUBLICATION OF DIRECTORIES OF PARTICIPATING PHYSICIANS WHICH WILL BE AVAILABLE AT SOCIAL SECURITY AND CARRIER OFFICES AND AT SENIOR CITIZENS' ORGANIZATIONS. WE WILL ALSO INFORM MEDICARE BENEFICIARIES OF THE PUBLICATION OF THIS DIRECTORY. IN ADDITION, TOLL-FREE TELEPHONE LINES WILL BE MAINTAINED TO DISSEMINATE THIS SAME INFORMATION.

NONPARTICIPATING PHYSICIANS CAN CONTINUE TO ACCEPT ASSIGNMENT ON A CASE-BY-CASE BASIS. HOWEVER, IN THOSE INSTANCES WHERE THEY CHOOSE NOT TO ACCEPT ASSIGNMENT, THEY ARE FORBIDDEN TO INCREASE THEIR CHARGES TO MEDICARE PATIENTS ABOVE THEIR ACTUAL PATTERN OF CHARGES FOR THE THIRD QUARTER OF FISCAL YEAR 1984. IF PHYSICIANS FAIL TO ABIDE BY THIS PROVISION, THEY CAN BE SUBJECT TO CIVIL MONEY PENALTIES OR TO DEBARRMENT FROM MEDICARE FOR UP TO FIVE YEARS OR BOTH. I AM SURE YOU WILL AGREE THAT BY FREEZING PHYSICIANS' FEES AND BY PROVIDING INCENTIVES FOR THEM TO ACCEPT ASSIGNMENT FOR ALL SERVICES, WE WILL BE SAVING MONEY FOR THE MEDICARE BENEFICIARIES AND THE TAXPAYERS.

PAYMENT FOR LABORATORY TESTS

PRIOR TO THE DEFICIT REDUCTION ACT, WE PAID HOSPITALS FOR OUTPATIENT LABORATORY SERVICES IN MUCH THE SAME WAY THAT WE FORMERLY PAID FOR HOSPITAL SERVICES, THAT IS, WE ESSENTIALLY REIMBURSED LABORATORIES ON THE BASIS OF THEIR COSTS. ALL OTHER OUTPATIENT LABORATORY SERVICES, THAT IS, THOSE FURNISHED BY INDEPENDENT LABORATORIES AND PHYSICIANS, WERE PAYED FOR ON THE BASIS OF REASONABLE CHARGES. THESE LABS AND PHYSICIANS WERE ALSO ABLE TO

ACCEPT ASSIGNMENT ON A CASE-BY-CASE BASIS. BUT WITH THE ENACTMENT OF P.L. 98-369, WE NOW HAVE THE AUTHORITY TO ESTABLISH FEE SCHEDULES FOR OUTPATIENT LABORATORY SERVICES. BY ESTABLISHING THESE RATES OF PAYMENT IN ADVANCE, WE WILL ALSO BE ENCOURAGING THE SAME EFFICIENT BEHAVIOR IN THE PROVISION OF OUTPATIENT LAB SERVICES THAT WE ARE WITH HOSPITAL INPATIENT SERVICES. FURTHERMORE, P.L. 98-369 ALSO MODIFIED THE ASSIGNMENT OPTION SO THAT NOW ALL INDEPENDENT AND HOSPITAL LABS ARE REQUIRED TO ACCEPT ASSIGNMENT, FORMERLY ONLY A REQUIREMENT FOR HOSPITAL LABORATORIES. IN THESE CASES, REIMBURSEMENT AT THE FEE SCHEDULE LEVEL WILL CONSTITUTE FULL REIMBURSEMENT, AND NO COINSURANCE OR DEDUCTIBLE WILL BE REQUIRED OF THE BENEFICIARY. THIS OFFERS PROTECTION AGAINST RISING OUT-OF-POCKET COSTS FOR THE MEDICARE POPULATION.

CONCLUSION

I HAVE JUST DESCRIBED THREE OF THE MORE RECENT SIGNIFICANT CHANGES TO MEDICARE. WE ARE OPTIMISTIC THAT THESE CHANGES WILL HAVE A POSITIVE IMPACT ON THE MEDICARE PROGRAM BY ALTERING REIMBURSEMENT SYSTEMS TO ENCOURAGE EFFICIENCY IN THE PROVISION OF CARE AND ON THE MEDICARE BENEFICIARY BY OUR CONTINUED COMMITMENT TO HIGH QUALITY CARE AND BY THE PROTECTION PROVIDED AGAINST INCREASED OUT-OF-POCKET COSTS.

I WILL BE GLAD TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator **Jepsen**. I thank you, Joe. The Chair would advise the panel that I am going to ask Bill Finerfrock to finish the chairing of this hearing as we build this record. This is very important, the establishment of trying to find an answer for some of the things we have been talking about today. We are all partly to blame for the current cost problem. We all need to be involved in coming up with solutions and in gathering information and records as these hearings do, they are very key in providing direction and guidance toward a policy that will fill the bill. One of my colleagues in the Senate, Senator Durenberger from Minnesota, recently noted we really don't have a health policy in this country but we do have a sick policy. The only program we currently have in place deals with people who are already sick rather than healthy, and I know that some of the things that are coming up are going to be talking about this and so on. I am sorry to miss them.

Bill Finerfrock is the chief of staff coordinating these programs for the Joint Economic Committee. He is my senior saff member and he was with Senator Brooke prior to coming with me, and this is his field of specialty. Those of you who have gotten to know him know. I think objectively I can say he is probably one of the better informed people in the entire Congress in all these areas, so I will ask him to finish, and I thank you for coming, and I know we have run a little longer than we all planned on. Mr. Snyder, I think you are kind of anxious to get going. I can kind of sense that. We need to get moving. Thank you very much.

Mr. **Finerfrock**. Mr. Weber, do you want to begin?

STATEMENT OF JOHN WEBER, MEDICAL SALES REPRESENTATIVE, MIDWEST SALES REGION, HEWLETT-PACKARD CO., CEDAR RAPIDS, IA

Mr. **Weber**. Certainly all of us at Hewlett-Packard want to thank you for the opportunity to share with you our medical technology, and just as the medical community is being influenced by the Government programs, obviously so has our marketing and research with the decrease in revenue. We have to address the lack of money availability, and so we are addressing the needs and the costs of medical equipment by trying to prevent product lines and technology that are designed to function as productivity tools for the medical community.

For instance, the Hospital Information System, which is a large computer system, centralizes and processes and aids the health care delivery team by automating the collection and processing the patient data. Both clinical and administrative computerized needs can be combined and coordinated through this one central system.

The data management capabilities used in conjunction with the patient bedside monitor, and this is a very small computer, very inexpensive computer that fits in with the bedside monitor, it will collect and calculate cardiac, renal and respiration data. The data can be reviewed by physician at any bedside or central station and can be printed out and put in the patient chart, thus alleviating valuable nursing time to do all of their charting and writing, and therefore our hope is to allow more patient-staff interaction rather than administrative duties. All billing, pharmacy and lab requirements can be handled from each nursing unit also, thereby maybe alleviating mischarges, those sorts of things, creating more revenue.

We have introduced a wide range of products in the last few years. Last year—we usually introduced about four or five new products a year. Last year we introduced 14 new products. Part of the reasons for this are the Government programs, and we have introduced a much wider product range. This will allow the smallest and the largest hospitals, hopefully, to provide the product that is right for their needs, thus avoiding overspending for a product that could be too sophisticated.

Creative financing is also available for any institution interested in low payments that can be expensed for tax purposes. The option to lease equipment over an arranged length of time and then purchase it at 10 percent at the end of the lease or the payment period, and this is ideal for any institutions, particularly in Iowa, where we have a lot of smaller hospitals.

We are also trying to provide local services in as many offices as possible. As small and rural as Iowa is, we have three central offices across the State with two engineers in each office providing repair and avoiding down time and avoiding prolonging the patient's stay.

And protection from technical obsolescence is certainly important to protect the investment of the medical equipment. And one of our philosophies is to manufacture products that will interface with products of future generations, and we have a commitment to be compatible with all of our other equipment, and the best way to make an analogy is that the first monitor systems that we have put out in the field in the 1960's are compatible with the system that we are manufacturing today, thus avoiding hospitals having to update their units by replacing every bedside unit. They can start one bedside at a time and it will interface with existing equipment.

We also have—we realize that the latest and greatest technology may not be used if it's not affordable, and we have dedicated ourselves by the end of the decade that we will be the lowest priced and most reliable vendor on the market, and I don't think this philosophy is probably unique to our company, but certainly the philosophy being adopted by the other medical vendors. Thank you.

Mr. **Finerfrock**. Thank you. Now, Mr. Snyder.

STATEMENT OF JAMES R. SNYDER, ATTORNEY, SIMMONS, PERRINE, ALBRIGHT & ELLWOOD, CEDAR RAPIDS, IA

Mr. **Snyder**. I am an attorney in Cedar Rapids, but like Dr. Swaney, who stated that he was representing the interests of the medical group, I do not think I can say that I am here representing the legal profession. In my 27 years of practice, I have not on one occasion sat on the plaintiff's side of the table in a medical malpractice case. On the other hand, I would say 80 percent of my practice is in the medical malpractice field in defending the hospitals and physicians. So I think the plaintiffs' bar would argue with me vociferously if I were to represent here today that I represent their interests.

Historically you probably all recognize that the so-called medical malpractice crisis started in the early 1970's. Whether this is considered a crisis or not is a matter of opinion. The plaintiffs' bar and patients might take the position that it is a crisis. Perhaps the defense bar and the insurance carriers might take an opposite view, but in fact the figures would indicate that approximately 2.5 percent of the total health care cost is attributable to medical malpractice claims.

I, in my prepared statement, have set out many statistics, facts, and figures which would serve no purpose to repeat those at this time. But out of curiosity, I asked my secretary before coming here today to find out just how many medical malpractice lawsuits I was defending at the present time. And she came up with a figure of 27. Now, you understand that within a week or two I might be closing a file because of settlement or concluding the litigation, but for every file I close, I will be opening a new one. This means that any time I look at my records I can probably come up with approximately 27 medical malpractice lawsuits that I am defending at any given time. This is a community of approximately 100,000 people.

Now, our law firm represents only one of three major malpractice carriers. If the other two law firms are defending the same number of lawsuits as I am defending, we are talking about approximately 75 pending lawsuits in Cedar Rapids at the present time that are being defended. Now, again whether this is of crisis proportion or not depends upon individual opinions.

What is the impact on the cost of health care born by medical malpractice? I think we can talk in terms of a direct impact which means money. It's going to be paid either by way of premiums, which by the way we are led to believe by the insurers will substantially increase next year and probably in the years to come. So the health care provider will be paying by way of either premiums, or if they are self-insured, they will be paying the judgment or claims out of their own pocket. This obviously, as we all know, will be passed on to the consumer. So that's the direct impact of the medical malpractice problem.

What are the indirect aspects of the problem? I would suggest that perhaps it could lead to a defensive practice of medicine. In other words, the more lawsuits against a physician or hospital, the more the tendencies might be to practice defensive medicine. In other words, perhaps more hospitalization, more testing, the higher costs of the medical care. This would be an indirect cost to the health care profession.

Also we should consider the cost in time and energy of the physician and hospital administrators, because it's not an easy proposition to defend a medical malpractice case. It takes much time on the part of the physician, it takes much time on the part of the hospital personnel to work with the defense lawyer in preparation for the trial of that lawsuit. This takes its toll not only in money, time they could be well spending on something else, but emotions. It's not an easy thing on emotions for a physician to have to defend himself, nor a hospital. This again would be an incorrect impact on health care costs.

There has been much said today, and I am not about to belabor the point, about DRG's, diagnostic related group. There has also been reference to Utilization Review Programs. Now, this might be all well and good insofar as attempting to hold down the costs of medical care, but I would suggest that it's counterproductive if we have what we refer to as a medical malpractice crisis. I would suggest that the more DRG's the more Utilization Review Programs, the higher that percentage is going to be of medical malpractice claim, and the higher the cost as a result of medical malpractice. I do not consider myself an expert on DRG's or utilization review, but I know that basically what we are attempting to do is either keep people out of the hospital to begin with or minimize the stay period once they are in the hospital. Now, how does this affect medical malpractice?

A good many of my lawsuits have to do with failing to diagnose an injury or an illness. In other words, the plaintiff is alleging that the physician should have diagnosed his problem sooner and as a result of that he would not be having the residuals he is claiming to have had in the lawsuit. How do we diagnose? We diagnose by testing. This ordinarily is done in the hospital. So if the physician decides not to hospitalize a patient and do proper testing, the more chance that there is going to be error in that diagnosis. So although when we are talking about the cost of health care, it might be proper to talk in terms of Government programs, DRG, utilization review, when we are talking in terms of quality of care, I think it can be counterproductive, and I would suggest that if we insist on this type of program, our medical malpractice is going to become a crisis, if it is not already there. Thank you very much.

[The prepared statement of Mr. Snyder follows:]

PREPARED STATEMENT OF JAMES R. SNYDER

Increasing litigation and rising jury awards are undoubtedly two of many factors affecting the cost of hospital and medical care throughout the country. Whether the claim or award is paid "out of pocket" or by a malpractice insurance carrier, it is a substantial cost in doing business as a health care provider.

Insurers contend that the continued and alarming escalation of the number and cost of physicians and hospitals professional liability claims will result in significant rate increases this year and the following years. One insurer reports that since 1979 the frequency of claims on a calendar year basis has increased more than 63 percent—from 3.3 claims per 100 physicians in 1979 to 5.4 in 1983. This translates into 5,870 reported claims, 2,757 more than in 1979. During the same period of time, the claims against hospitals have risen from 1.8 claims per 100 beds in 1979 to 3.1 claims per 100 beds in 1983.

The average payment per physician claim has risen from $27,400 in 1979 to $53,500 in 1983. For hospitals during the same period of time, the average payment for each hospital claim as risen from $11,700 in 1979 to $23,900 in 1983.

The total premium dollars paid in 1979 for medical malpractice insurance was 1.4 billion dollars as compared to two billion dollars in 1983. The average cost of malpractice insurance for a physician is 3.5 percent, or $3,500 for each $100,000 in insurance coverage. Malpractice insurance premiums account for approximately 1 to 3 percent of the total health care cost.

Jury Verdict Research, Inc. reports that average jury awards in medical malpractice cases increased five times from 1976 to 1982 from 192,344 to 962,258. The same research company reports that malpractice verdicts over one million dollars increased from four in 1976 to 45 in 1982. They further report that out of court settlements are growing at a corresponding rate.

The response of the health care providers to increased rates might be varied, with alternatives to insurance coverage coming about in different forms. It has been suggested by experts in the field that there is a move toward greater risk assumption by health care providers. In the case of physicians, there has been an emergence of physician owned professional liability insurance companies. In addition, some physicians have resorted to practicing without professional liability coverage. Hospitals are moving toward a greater assumption of risk by the hospital itself, either in the form of partial or total self insurance.

To some extent efforts are being made to have the government, whether it be state or federal, intervene in the medical malpractice problem. On the federal level, H.R. 5400 has been introduced and referred to the Committee on Ways and Means. It would amend the Medicare law to establish an alternative system for settlement of medical malpractice claims in the case of injuries allegedly arising from health care services provided under federal funding. Under the bill, an injured person would be foreclosed from bringing any civil action against a provider if the provider gives a written tender to pay compensation benefits (as defined in the the bill) with respect to such injury. Several states have similar legislation pending, which would if enacted accomplish the same purpose on a state level.

Remedies are also being sought by the health care providers by way of better health care training and education in risk management techniques. No single remedy will solve the medical malpractice dilemma. It will take a combined effort on the part of physicians, hospital administrators and the legal profession to bring about a workable solution.

Mr. **Finerfrock**. Thank you, Mr. Snyder. In your prepared statement, you referred to a bill, H.R. 5400. Do you support that legislation and could you give a brief explanation of what that would do?

Mr. **Snyder**. No, first of all I do not support this legislation. It is a Federal bill whereby a patient would be prohibited from bringing a lawsuit if the health care center or the physician would come forward and make what we refer to as an offer of settlement. In other words, the health care provider could come forward, acknowledge that malpractice had been committed, and make an offer to the injured patient.

Under H.R. 5400 this would prohibit that patient from starting a lawsuit, at least until that so-called administrative function was concluded. I for one do not go along with any such program. Some States have attempted, and I think the State of Florida is one, that has made a similar effort on a State level.

The Federal program would only have to do where Federal funding was involved, such as Medicaid or Medicare. It would not apply where a private insurance company were paying the loss, for example. As I have stated, several States have attempted to do the same thing. In my limited practice, I feel that these type programs only increase the problem and not solve it. I think those States that have attempted to come out with administrative remedies as opposed to judicial have found that perhaps it only adds to the cost and delays justice. In that in many States it's been unconstitutional to take away access to the courts, so if we have administrative procedure it merely serves as a delaying tactic in finally ending up in the court procedure.

I do not think it has worked too well, I am not an expert in what these States have found in relation to their programs, but no, I would not be in favor of such a program.

Mr. **Finerfrock**. Thank you, Mr. Tilghman, we heard a lot of talk here today about the patient end of things, and we have noted that there have been significant reductions in the average length of stay and decreases in the amount of hospital admissions, and we know that transfers into increased costs, but what assurances are we getting that there is not a corresponding decrease in the quality of care?

Mr. **Tilghman**. If I may go to my testimony, have basically three actions that we are focusing on to assure there is no drop in quality of care because of the DRG application. Probably the bulk of that focus is by the peer review organizations. We are contracting with these. We have one in Iowa, PSRO—Iowa Foundation for Medical Care and it's going to be the responsibility of the PRO's to monitor a number of aspects in connection with the DRG's. One is where they have a transfer to another hospital, there is a look at those, to make sure there is an appropriate transfer. In general a very intensive focus on hospital inpatient care, more so than it was under the PSRO program, to make sure there is no tendency to push patients out before they are medically ready to be out of the hospital. We expect that to work pretty well. It's a brand-new program, both for DRG's and for PRO's, and we will be monitoring those pretty closely to make sure there is no drop in quality of care. That is a major concern, both in Congress that they expressed when they passed the bill and also by our agency to make sure there is no drop in quality.

Mr. FINERFROCK. What provisions are there in analyzing the cost reductions which DRG's may bring about in Medicare to make sure that those are not simply just cost shifting, just going from the Medicare program over to a private pay program?

Mr. TILGHMAN. That with any major change in a large program like Medicare, that we have certain thoughts in mind when we first implement the program. We use the reimbursement system as a lever to bring about changes that we like to bring about in the health care industry. We can usually forecast what the first and second level tier effects of that change are going to be. Sometimes it's very difficult to project what the third and fourth level changes will be, and it may take years to determine maybe the most significant changes that resulted from the official level we applied. We aren't real sure what's going to happen as far as the shifting of costs from Medicare patients to private pay patients.

What we have seen, Iowa is a good example of this, is that a lot of your other third-party insurers, such as the State Medicaid programs and your major Blue Cross and Blue Shield and the mutuals, like that, are bringing about changes in their own reimbursement mechanism to preclude something like that happening. They are moving to similar type prospective system, so I think there is this—because of the lever that medicare is applying under the system, we are seeing these third and fourth year effects that we didn't really plan or anticipate. We just wanted to save medicare money, knowing it was going to bring about some other changes in the way other people may pay for third-party care, and here in Iowa, for example, the Medicare program is on our prospective system, and both the Sioux City and Des Moines plans have also gone on a prospective system, their private lines of business. As far as how we in the Medicare Program would monitor that possible cost shifting, we don't have any specific plans in mind as to how to do that, but it looks like we don't have to because the other third-party payers are doing that on their money.

Mr. FINERFROCK. Mr. Oakley, in your prepared statement, and this relates to what Mr. Tilghman was just saying, one of the proposals that's been mentioned was a way to avoid cost shifting, to go to all-payers system, and I believe in your prepared statement you indicated that you opposed an all-payers system. Could you explain why?

Mr. OAKLEY. First of all, we would be concerned going to—we would be concerned going to an all-payers system without the kind of study of that very question as to whether, one, it takes place, who does it adversely affect, and three, would that work out as a matter of competitive marketplace as opposed to imposing regulation. Regulation generally falls far short of its initial expectations of success when dealing with a large problem such as this. So history alone shows us that regulation doesn't work very well, and that is pure and simple regulation.

Second, however, the initiatives that have been already started in one study, and second, dealing with the overall cost problems in general, seem to be working. An all-payer system, it seems at this point, would be an anomaly, at least in Iowa. I can only speak to Iowa. And fourth, what ought to be of some concern to—and this I will put on my Blue Cross-Blue Shield hat and take off the industry hat, if you will—is that in many States where all-payers systems have been adopted, they have legislated the differential that Blue Cross and Blue Shield enjoys in those States right in their all-payers regulation. They get a 6 percent or 10 percent or 12 percent statutory discount off of what everybody else is charged. That differential is very small and on a selective basis. And that's why the Iowa marketplace is, frankly, so competitive. So one, we should study it, two, those who advocate it ought to look at what has occurred in other States where it has occurred, New Jersey and others as to what has really been the effect of it. I might say at this point that H.P.C.I. the legislature, ourselves, and others in our health data commission, which is now just getting up and running, will go a long ways to finding out what is happening with those costs and what it's generating, but I think in Iowa it's inappropriate at this point to consider an all-payer system and that's why I oppose it.

Mr. FINERFROCK. Thank you very much. On behalf of Senator Jepsen, I would like to thank all the panelists for appearing today, and as has been mentioned, your prepared statements for those of you who summarized will appear in their entirety in the hearing record. Thank you.

The last panel is Russell Knuth, Pioneer Hi-Bred International; Edward Petras, acting director, Medical Association, HMO: Bernard Grahek, clinical coordinator, Voluntary Hospitals of Iowa; Dick Johnson, Rockwell International.

Mr. Knuth, you may proceed. As we mentioned earlier, your statement will be introduced to the record in its entirety. You may give your name or you may proceed however you wish to proceed.

STATEMENT OF RUSSELL KNUTH, PIONEER HI-BRED INTERNATIONAL, INC., JOHNSON, IA

Mr. KNUTH. Thank you, Bill. I represent industry. We are fundamentally Central United States based, producing our hi-bred seeds. We have about 3,000 employees, and we are located and have locations and employees in 30-some States. About 6 years ago our health care costs nearly doubled. When we looked at that as management and projected that if this continued at the same rate, that possibly in a few year we wouldn't be able to provide health care coverage for our employees, obviously that would create quite a problem. What we did was to analyze what we could do, and what we came up with was one that's been alluded to here a preventative medicine type approach, one where we would identify problems at the early stages and treat them, so there would be less traumatic event for the employee and their families and obviously less cost. And here is what we came up with.

We provide full blood chemistries for our employees and their spouses that are over the age of 40 annually, and the vitals, which of course include blood pressure, height, weight, pulse and the urinalysis.

Initially all employees received this, and for those employees under the age of 40—and we chose the age of 40 because it seemed that the first 40,000 miles go on relatively easy and after that you need more maintenance. For those under the age of 40 we provide the basics again which provides blood pressure check for early detection of hypertension, still one of the major killers in the world, particularly the United States. We also provide a urinalysis which then would also address the number three killer in the world, or at least a detection of glucose spillover for diabetes. So No. 1 and No. 3 are addressed by under age 40. This is done annually and it is done in the workplace. I think it's important to bring medicine into the workplace and we understand it the best we can as lay people. It's done on company time and it is company paid for. Breakfast is furnished for those of us that need to fast our 8 hours, and I think that's an important element in the employee relations. It's a time to talk about our health problems together.

And in that same vein, every aspect of it is completely confidential and private. The only thing as the corporate administrator of this program, the only thing I provide to the company are statistics and trends so that we can analyze and provide more funding for an even complete and better program. What really turns out is it becomes very public, because once the results come back to the employee, and it is mailed to their home along with an explanation, a lay person explanation of all tests that were taken, what happens is that those that have elevated tryglycerides are usually in one corner of the break room, and the diabetics are in another, and the elevated cholesterol and blood pressure in another, talking over what they are doing and what their doctor prescribed, and it makes a very supportive group for each of those, two of which I am a part, and it's a very satisfying feeling.

Now, I want to emphasize this is provided for employees and their spouses, because we provide health care for the family. We have—it's voluntary and company-paid-for as I indicated. We have 97 percent voluntary participation by our employees and 70 percent participation by our spouses.

In addition to the testing I have told you about, we try to do an additional test each year that is of concern to the medical community. Some of those that we have done so far are the hemoccult, Titmus eye test, audiometric, pulmonary function, and so in the sequence of 4, 5 years we have exposed employees and their spouses to some medical functions that they can do on their own with their own physician to have a more complete and more aware type health program.

We also have two incentive programs called COP and TOTE. COP, or cut out puffing, and we all know that two pack a person shortens life expectancy on the average of about 7 years, and obviously their health care costs are higher. We pay employees $150 to quit smoking for 1 year. If they continue to quit smoking the 2d year, they receive another $75. I think if you wanted to—I think it's one of the most cost effective things that we can do immediately. Obviously with the tobacco industry spending about $2 billion a year to encourage you to smoke, it's a tough program to promote, telling it like it really is.

On our TOTE Program, trim off the excess, much more successful. You have automatic media support. Every magazine, newspaper, and television tells you how healthy it is to be slim and trim, and fast, and walk, and trot, and ride bike, and swim, and whatever. We are no different than the national averages. About 39 percent of our employees did smoke and 30 percent of our employees were overweight to the tune of 29 pounds. That's about national average. Both of those are cost-effective programs. What's happened in those? I would like to share some bottom line things now.

What's happened, the first year that we did our health testing, 6 percent of all our employees had at least one significant abnormality, one that needed immediate medical attention. Today, 6 years later, six-tenths of 1 percent are in that category, and I suspect half of that are new employees and spouses coming on board. I don't know that. I suspect that. Which tells us there has been significant lifestyle changes of employees and spouses, and/or they are on proper medication. Now, to industry that's bottom line, those are dollars.

For incentive programs, 15 percent of our employees have quit smoking, and we have lost over 4 tons of waste. Now, I think there is another issue along with the dollars. That most of the life expectancy lost through overweight and smoking is not through the productive years. Just watch the obituary columns and they will tell you they usually happen between 66 and 69 years of age. Meaning that after working 30, 40 years, you are going to die 2½ years after you retire.

So this program not only helps the productive years, I think, and it's in line with Pioneer's philosophy of staying with the family and wanting the employee to enjoy the well-earned twilight years or whatever we would like to call them.

We feel that this program—we believe in it, and regardless of how indepth program that any company would have, I think any endeavor, whether it be blood pressure clinic, an awareness, a poster campaign, they are all winners, and I would support and encourage every industry to become involved in this, and help themselves. Bottom line dollars are that 6 years ago our costs were $980 per employee. Six years later we are looking at $1,130 per employee. At the normal rate of inflation I think it's reasonable to believe that we would be looking at $2,500 per employee today without preventative medicine, which is in the tune of $2 million a year, and might be why we affirm and believe in the programs so strongly. And probably the most important thing is that our employees look at our health screening program as one of their most important benefits, and that is what it was really designed to do. Thank you.

[The Pioneer Hi-Bred brochure referred to follows:]

Health Guard Incentive Programs

In addition to the Health Guard program, two incentive programs are available for those that qualify.

T.O.T.E. – TRIM OFF THE EXCESS

On the average, life expectancy is shortened one year for each 10 pounds of excess weight.

We will be using a weight chart based on height and skeletal structure recommended by Blue Cross-Blue Shield to determine those eligible for the T.O.T.E. program. $5.00 will be paid for each pound lost down to the desired weight.

For maintaining the desired weight for an additional year a $75.00 gift of your choice will be offered.

C.O.P. – CUT OUT PUFFING

Two packs per day on the average shortens life expectancy by 6 years.

Quit smoking for one year and you will receive a $150.00 cash award.

Abstain for another year and you'll receive a $75.00 gift of your choice.

For information regarding the Health Guard program contact your Division Health Guard Coordinator or the Employee Relations Department.

THE HEALTH GUARD PROGRAM FOR PIONEER EMPLOYEES

It is becoming
more and more evident
that medicine and technology alone cannot
adequately prevent or treat the major diseases of
modern society. Instead, we should recognize that how
we live can determine how long we live.

Therefore, Pioneer Hi-Bred International, Inc.
has initiated a voluntary, cost-free health screening program
for employees, to assist in identifying and treating
potential health-related problems.

Over the years, Pioneer has added many programs
to help employees and their families cope with
the financial problems caused by serious illness.
At the same time, we recognize that helping prevent
serious health problems can be an even greater benefit.
Early detection of potential problems can make this possible.

And that's what Health Guard is all about.

PIONEER HI-BRED INTERNATIONAL, INC.

Health Guard . . .

. . . a program to spot the signs of illness before it's too late.

The Health Guard program consists of the following tests:

Health History Review

A questionnaire on your medical history

Physical Data

- Height
- Weight
- Pulse
- Blood Pressure
- Temperature

Urinalysis

- Albumin
- Glucose
- Ph
- Occulut Blood
- Specific Gravity

Hematology Survey

- White Blood Count
- Red Blood Count
- Hematocrit
- Hemoglobin
- MCH
- MCHC
- MCV

Blood Chemistry Screen

- Phosphorus
- Calcium
- Glucose
- Blood Urea Nitrogen
- Bilirubin, Total
- Cholesterol
- Albumin
- Total Protein
- Alkaline Phosphatase
- SGOT
- LDH
- Uric Acid
- Bun/Creative Ratio
- SGPT
- Total Lipid
- Bilirubin, Direct
- Tryglycerides
- Iron
- Sodium
- Potassium
- Chloride
- A/G Ratio

PMI Physical Measurements Inc.
has been selected to gather the necessary data
and samples for this program. Data collected
will be coordinated with laboratory analysis and
sent to an authorized physician for review
and interpretation.
A complete report of the tests will be mailed
to your home.

If the need arises, other tests may be added
to the program.

Health Guard is not meant to replace
your present health care program,
only to be an extension thereof.

If an abnormality should be discovered in
your tests, we recommend you seek the advice of
your family doctor immediately.

Mr. FINERFROCK. Thank you very much. Mr. Petras, please proceed.

STATEMENT OF EDWARD J. PETRAS, ACTING DIRECTOR, HMO MEDICAL ASSOCIATION, DUBUQUE, IA

Mr. PETRAS. Thank you. Prepaid health plans or health maintenance organizations (HMO's), as they have come to be known, offer a viable alternative to modifying the growing cost spiral of health care costs.

As an alternative HMO's do not provide ultimate and complete solution to the cost/benefit dilemma, however, do make significant changes in health care delivery systems where key elements exist which make them feasible.

These key elements are:

First: High benefited employer groups with large first dollar covered health insurance plans complimented with low employee contribution levels for monthly premiums.

Second: Benefit programs which attempt to avoid unnecessary and routine health care expenses by requiring an inpatient setting for reimbursement.

Third: An over-supplied seller base—hospitals and physicians—developed in an unorganized fashion so that the delivery system is nonexistent in a structure format.

Fourth: A long-established population base of a minimum of 60,000 to 100,000 to convert patients into plan members in the insurance structured prepaid plans contracting with local physicians, and a minimum of 300,000 persons in a transient population to establish a staff model, salaried physician plan.

The HMO has a number of key elements which distinguish it from the traditional fee-for-service reimbursement arrangement.

First: Prepayment of services on a monthly basis with a premium similar to an insurance plan.

Second: Medical and hospital utilization goals which are lower than the average for the community and require behavior modification for medical practitioners, hospitals and plan members to avoid excessive over-utilization of services.

Third: A voluntarily enrolled member base which is committed to the program for a 12-month period in order to maintain the revenue base and actuarial soundness of the plan.

Fourth: A financial risk/reward relationship with physicians and hospitals to develop ownership in the fiscal and utilization goals established by the plan.

Fifth: A predetermined set of benefits which attempt to assist in the modification of physician/patient habits while developing an attractive benefit alternative.

Sixth: A statistical base of data to measure programs against plan utilization objectives while providing information on a day-to-day plan management.

Seventh: A patient education program which seeks to stimulate interest in habits concerning nutrition, exercise, smoking and alcohol which significantly contribute to eventual health deterioration.

HMO's have proven that in the right setting they can reduce costs by shifting care to an outpatient setting from the traditional hospital based care without jeopardizing the quality of service provided.

This was documented by a Johns Hopkins University study completed in the mid-1970's which indicated that the quality of care is maintained while reducing inpatient costs some 15 percent to 20 percent.

In the past 6 months, a major study prepared by Rand Corp. has added further proof to this data base using a long-established prepaid program in Seattle, WA.

This does not mean that the HMO's are flawless in their success rate. The late 1970's were marked with a number of plan failures similar in cause to company failures in other industries.

Most were undercapitalized, ill-managed, inappropriately structured, or conclusively unfeasible from the start. As mentioned earlier, there are certain ingredients which are necessary to enable them to survive.

These elements of failure are not the sole proprietorship of the HMO industry. However, feasible, well-capitalized, and well-managed HMO's can make a significant contribution in bringing a competitive element to the health financing marketplace and bring structure to the delivery system by organizing providers and hospitals into a formal structure.

The significant presence of HMO's can spawn further reaction from the marketplace by other HMO's sponsored by Blue Cross or insurance companies, Preferred Provider Organizations (PPO's), plans which offer price discounts and quality assurance review similar to the foundations for medical care of the late 1960's. Also, a significant HMO presence can develop direct provider contracting with buyers such as employers, the Health Care Financing Administration (HCFA) and the State Welfare Department to innovate change in both private and public financing arenas.

The future of HMO's will require adaptation and flexibility in the marketplace. The concept itself thrives on efficiently competing within the health care marketplace, which perhaps has become somewhat margin fat through the years of constantly feeding by a cost-plus reimbursement system. Just as reliable as the laws of nature, competition in a "real marketplace" has always caused sellers to carefully consider duplication of services and inefficient operation and growth in quest of a competitive price.

This likewise will remove the inefficient HMO's as the level of service and financing becomes more efficiently balanced.

No one can foresee how long before that turn-around takes place; however, the marketplace pressures of HMO's, PPO's, DRG's, direct contract relationshps, self-insured employer trusts, accentuated by over-supply of providers and facilities may certainly accelerate the process.

A major underlying question remains as the elements of cost containment collide over the next few years and that is, while costs may begin to level, when will one know where the quality threshold has been jeopardized.

Mr. FINERFROCK. Mr. Grahek, please proceed.

STATEMENT OF BERNARD M. GRAHEK, CLINICAL COORDINATOR, VOLUNTARY HOSPITALS COOPERATIVE ASSOCIATION OF IOWA, CEDAR RAPIDS, IA

Mr. **Grahek.** Thank you. Voluntary Hospitals Cooperative Association of Iowa, known as VHi, is a group of 14 hospitals located in central and eastern Iowa, which has been looking to the future to assist in the preserving the health care delivery system in rural Iowa by creating a system of local not-for-profit hospitals that meet stated criteria which strengthen and expand voluntarism in the health care field by improving the efficiency and effectiveness of each member hospital and increasing their competitive position in the health care system and by sharing their efforts to provide the best possible care through large system advantages while maintaining local initiatives and direction. VHi is a multi-hospital system. It is a system which takes advantage of the national multi-hospital system, The Voluntary Hospitals of America. This is made possible through the membership of our "anchor" hospital, St. Luke's Hospital, Cedar Rapids, IA. Through shared efforts, the members take advantage of the regional multi-hospital system whereby local hospitals in both rural and urban Iowa share similar goals and work toward the common good, that is to givo the patents they serve the best possible care by the most economical means.

The VHi is a partnership—all members have equal voice and vote. Local control is preserved, and all members are encouraged to use the system and utilize its programs. We are in existence to preserve voluntarism at the expense of the for-profit sector. Our goal is to maintain local autonomy and control.

The VHi hospital is a strong, not-for-profit, voluntary hospital. It is independent of any other system or group, with strong, enlightened leadership, and compatible in goals, marketing, and patient care philosophy with other members of the VHi organization.

This partnership is an innovative program offering services and resources enjoyed by the shareholders, as I stated earlier, of the Voluntary Hospitals of America. The Voluntary Hospitals of America is the largest hospital system representing voluntarism, whose members are all very prestigious not-for-profit hospitals located throughout tho United States.

Economies of scale savings are obtained through group purchasing. Purchasing contracts negotiated by VHA, in pharmacy, capital equipment, medical/surgical supplies, reference laboratory, and forms purchasing. In addition, VHi has negotiated 15 local contracts ranging from food purchasing to linen purchasing.

Technical services are being studied and established to provide the rural hospitals with technology not financially feasible for them to provide "in house." VHi has recently placed a mobile echocardiology unit at the disposal of nine hospitals in rural Iowa, eliminating the need for the patient to travel, keeping the patient in his community while being given the latest in technology and professional expertise. Other technology is in the planning stage and will be made available in the future to the same rural hospitals.

As you have heard earlier in the testimony by Sally Miller of Anamosa Community Hospital, so many times that hospital is the focal point of the community, the only center of health care services, and by and large the largest employer of the given community, and therefore these kinds of things will make it continue to be a viable part of the rural community.

Sharing, eliminating duplication in marketing efforts, community relations, and other disciplines are goals of the VHi. Sharing professional personnel and expertise is obtainable through a multihospital system.

Pharmacists at St. Luke's Hospital, for example, can certainly act as consultants to the pharmacists of the rural hospitals that are members. These are the types of things happening which virtually eliminate the high cost of consultation work. The VHi system is designed to have the financial benefits go to its members and in turn, the patient, and not to a corporate profit.

Productivity and efficiency is paramount in the hospital industry today. VHi is actively engaged now in development of a program for its member hospitals, with a meaningful data base, to establish needed parameters in producing units of service that can be compared, and that the members can assist one another, if they have a better mousetrap, so to speak, than another member, then they can share with one another to do a better job.

We have been in existence only a year. Many dollars are being saved by the members of the VHi. Many more will be saved in the future because of the members' commitment to the system and to one another. Sharing for the common good is paramount.

Providing community health care services through voluntary, not-for-profit organizations has a rich and very successful tradition in the United States. In most cases, not-for-profit hospitals were established to meet needs identified as important to the community, but not amenable to private, for-profit or governmental solutions. Not-for-profit hospitals have been responsive to community needs, funded through local community efforts, and have traditionally reflected community control in their organizational purpose and design.

It would behoove the Government to harness the bureaucracy that they have established and the many, many regulations that have been forthcoming from the bureaucracies, because only through this has high cost continued to go about. As Senator Jepsen indicated, that the Senator from Minnesota stated we did not have a health policy but a sick policy. I would suggest that the sick policy is in the bureaucracy of the Federal Government and that the people of this country would be well served if the Congress of the United States would indeed harness that bureaucracy. Pioneer, you heard just a moment ago, they have a health policy, they know what it's about, they are working toward a goal. I am certain the Government did not come in and establish their regulations and rules by which they are operating.

VHi is committed to preserve the quality of life for all Iowans by having its members effective to meet the challenge now and in the future. Thank you.

Mr. FINERFROCK. Thank you very much, Mr. Grahek. Mr. Johnson, please proceed.

STATEMENT OF G. RICHARD JOHNSON, ROCKWELL INTERNATIONAL, CEDAR RAPIDS, IA

Mr. JOHNSON. Thank you, Bill. I have been asked to comment today on what Rockwell International here in Cedar Rapids has done to address health care cost containment and also our observations on what is needed here in this community of Cedar Rapids.

The health care system in Iowa and this Nation is undergoing a transformation, changing the way we receive and pay for health care. These changes are occurring because private citizens and leaders in business, labor, government, medical care and other groups have learned an expensive and valuable lesson: In the health care arena, business as usual is not always good business. At a time when corporate and personal budgets are tight, the purchasers of health care, such as businesses, unions and individuals, expect purchasers of health care such as businesses, unions and individuals, expect purchasers of health care, such as businesses, unions and individual, expect efficiency in the use of their health care dollars. This requires the health care delivery system to use its financial, material and human resources as cost effectively as possible.

Cost of health care has had a more dramatic impact on corporate costs in recent years. As an example, Rockwell's health care expenditures for its Cedar Rapids-based employees have increased an average of 15 percent each year for the past 5 years. This cost escalation directly affects our overhead cost and in turn, the cost of our product. If left unchallenged, this rate escalation would price us out of our highly competitive marketplace.

To respond to this issue, Rockwell, like many industries around the country today, has undertaken a variety of activities geared to level the escalation of health care costs.

Since 1981, Rockwell has been involved in health care management activities that include but certainly are not limited to the following:

In January of 1981, Rockwell implemented an in-house pharmacy for its employees and dependents. Currently, our pharmacy fills approximately 120,000 prescriptions each year and has saved several hundreds of thousands of dollars.

Since July of 1981, Rockwell has been very active in both the statewide health coalition, the Iowa Business Labor Coalition on Health, and the local Cedar Rapids coalition, the Employer's Health Association. These coalitions are important in that their membership is comprised of business, labor, government and health care providers. This public-private partnership has been instrumental in conducting ongoing steps to better manage our health care costs such as:

Transforming the State's Health Planning Agency into the Health Policy Corp. of Iowa.

Stimulating cooperative dialogue between purchasers and providers of health care.

Recommending changes by employers from "first dollar" benefit plans to cost sharing plans that include incentives.

Supporting the creation of the Iowa Health Data Commission to make information on hospital and physician charges available to aid individuals in their health care decisions.

Developing public education efforts to increase the awareness of the health care cost problems.

In 1982, Rockwell implemented several revisions to its health benefit plan to decrease overutilization of medical services and to eliminate unnecessary care. The plan provisions include the following:

Implementation of an up-front deductible for all medical services of $100 per person, $200 per family.

Establishment of a 10-percent employee copayment after the deductible.

The addition of an incentive which provides 100 percent coverage rather than 90 percent coverage after the deductible for the services that could be handled in less costly settings such as:

Ambulatory surgery, second surgical opinions, extended care/skilled nursing facilities, home health care, maternity/birthing centers.

As an ongoing effort in the last 3 years, we have been providing material and information to our employee/dependent population on the cost of health care. Wise and prudent buyers utilize delivery system properly and also the options that are available for an improved, healthier lifestyle. This education and awareness effort has been conducted through employee meetings, internal publications and letters to the individual home.

To further impact our health cost containment activities and to improve our education programs, we have been working with our insurance carriers on proper health care management. These ongoing activities center primarily on:

Improving carrier administration of our benefit contracts relative to coordination of benefits, subrogation and ineligible payment enforcement.

In addition, to develop specific health cost management reports that will assist us in identifying specific problem areas, either in the purchase or delivery of care, and in identifying further needs for employee education and awareness.

While these activities are necessary and have provided results, additional action is still required. Each element of the health care delivery system has unknowingly made a contribution to this health care cost problem. It will take commitment on the part of all the parties to resolve the problem. If any one segment responds with change independently of the other segments, negative impact can result in the form of cost shifting or a decrease in quality of care for certain individuals. The Government is the one segment that has most visibly made changes through the DRG, prospective payment process recently implemented. It is frequently argued, and has been argued here earlier today, that these changes potentially have appeared as cost shifting and also a decrease in quality care.

Therefore, all segments of the health care spectrum must work together to objectively develop a means to down-size a massive health care system that has cost inefficiencies, and at the same time maintain the present status of high quality. If effectively accomplished, the potential for negative impact can be lessened.

The health care delivery segments in Cedar Rapids are diligently addressing the issues to arrive at workable solutions. In January of 1984, the Community Advisory Council, an arm of the local coalition comprised of members from business, labor, physicians, dentists, and hospitals jointly initiated a project to develop innovative ideas and concepts on how the community as a whole can cooperatively work together to improve the efficiency of our health care delivery system. The initial phase of gathering thoughts and ideas has been completed. The second phase of procuring a consultant to evaluate and analyze this information for the purpose of developing a community-wide health strategy is currently in process. This type of activity is critical to this community as it has the clear potential of becoming a model of success in proving that private sector initiatives can achieve a resolution to the health care cost problems and do so in the best interests of the community. The emphasis must continue to be centered upon joint health care planning in this community. Thank you very much.

Mr. FINERFROCK. Thank you, Mr. Johnson.

At the hearing in Washington, one of the points that was made by Chrysler Motor Co. was similar to what both you and Mr. Knuth have mentioned here, that there is a direct cost in their product as a result of health costs. Chrysler, for example, has estimated that $500 in costs of every car they put out is directly attributable to the costs of health care they provide for their employees, and a number of companies are doing some of the things that you are doing. Do either of you, both you, Mr. Johnson, Mr. Knuth, believe there is applicability of some of the things that you are doing with regard to the Federal level programs?

Mr. JOHNSON. Oh, I certainly think there are. I believe that some of the initiatives that private industry has taken may have applicability to the Federal Government and some of the programs that exist there. I also think that, to expand on your question a little bit, that we can learn a lot from each other in what's going on within this whole health care movement, and we certainly exchange information with other industries and across the nation. And I think if we can work in communicating this issue and try to have us all better understand the elements and to make sure that all people understand that it's not one piece of pie that's at fault, that if we can work this from a cooperative standpoint, we all have a lot to learn and a lot to gain from it.

Mr. FINERFROCK. Thank you. Mr. Knuth.

Mr. KNUTH. Yes, I agree, but I would like to make a comment and accept some responsibility as industry that over the years we become somewhat maternalistic, provide full care and therefore eliminate the incentive of employees to look at better ways to contain costs and better ways to implement health care, and that on a 50-50 basis we probably were more like 28 in not providing those incentives, and it could be that's why we as industry then have taken a vertical approach and turned around and went the other way. I think we do need to accept that responsibility.

Mr. FINERFROCK. At Rockwell, and I believe at Pioneer also, you mentioned you have an information insert program where you periodically provide your employees with information, and I believe Pioneer has a similar program, if I am not mistaken, where you have inserts that go into paychecks on health care?

Mr. KNUTH. That is correct, and we have quarterly mailings to our employees, plus we have a newspaper for each of our 22 divisions and one section is devoted to wellness in each issue.

Mr. Finerfrock. One of the—I have seen some of the inserts that you put in and it struck me that many of those would be beneficial for many of the medicare beneficiaries, and seeing as most of those people are receiving Social Security checks, we could very easily put similar types of inserts into Social Security checks. Is that a very costly program for you?

Mr. Johnson. Not really. Once you begin to print these, the costs of printing these becomes very, very small. And we also take advantage of these publications that are available from other sources, HCPI, or Blue Cross-Blue Shield or Metropolitan, or other people that provide good information in this area. We don't hesitate to use their information if it's meaningful and supports what we are trying to accomplish.

Mr. Finerfrock. How many—Mr. Grahek, how many Iowa hospitals are members of the Voluntary Hospital Association?

Mr. Grahek. As I said, 14 presently.

Mr. Finerfrock. And they are all affiliated through St. Luke's?

Mr. Grahek. All affiliated through the anchor hospital, St. Luke's, and the reason for that, as I said, is the member or the shareholder in the Voluntary Hospitals of America, and all those services, assistance and developments can come only from the voluntary hospitals because of that St. Luke's tie in.

Mr. Finerfrock. Are these primarily rural hospitals then or is there a mixture?

Mr. Grahek. It's a mixture of rural-urban, and as I said in my testimony, what we are striving to do is to keep a health system intact in the State of Iowa. We are a rural State and I think those people in rural Iowa need as good a quality of care as we get in the urban areas, and so in our situation we have Burlington, Davenport, Clinton, Dubuque, Cedar Rapids, Waterloo, which we have now Manchester, Maquoketa, Henry County in Mount Pleasant, Fairfield, and Boone County, and Fort Dodge as the hospitals that are represented in our group. In addition to that, we have Anamosa, John McDonald in Monticello, Vinton, VA Gay Hospital, that are all affiliated with St. Luke's in a management situation, so they too benefit from the programs at both VHA and VHi. This country is going to see by 1990, 25 such systems such as Voluntary Hospitals of America, and your for-profits, Health Care Corporation of America and so forth. That will be the survival mechanism for the hospitals in this country, one of the survival mechanisms. Hospitals will not be able to stand on their own and survive, whether they be urban or rural.

Mr. Finerfrock. You have a similar situation with HMO's, don't you, where a lot of them are having to become affiliated or in some way affiliated with one another so that it's not just that you need HMO in a particular community but as part of that system?

Mr. Petras. Well, the concern you have is that you don't recreate Blue Cross and Blue Shield. We firmly believe that what we want to do is maintain local control because that's where you get the most responsive change to utilization. However, as the final commitment is drawn, and I think this gentleman is correct, bigness will be the word, networking with the oversupply, there will be relationships where we may even have—next will be physician groups going together to provide services on a direct contract basis with major local services.

Mr. **Finerfrock.** Does anyone have any additional comments they would care to make in closing? Thank you all for coming today.

If there isn't anything else then, the committee now stands adjourned.

[Whereupon, at 4:50 p.m., the committee adjourned, subject to the call of the Chair.]

APPENDIX

(From the Cedar Rapids Gazette, Aug. 30, 1984)

Gripes about health care aired at congressional hearing

By Vanessa Shelton
Gazette staff writer

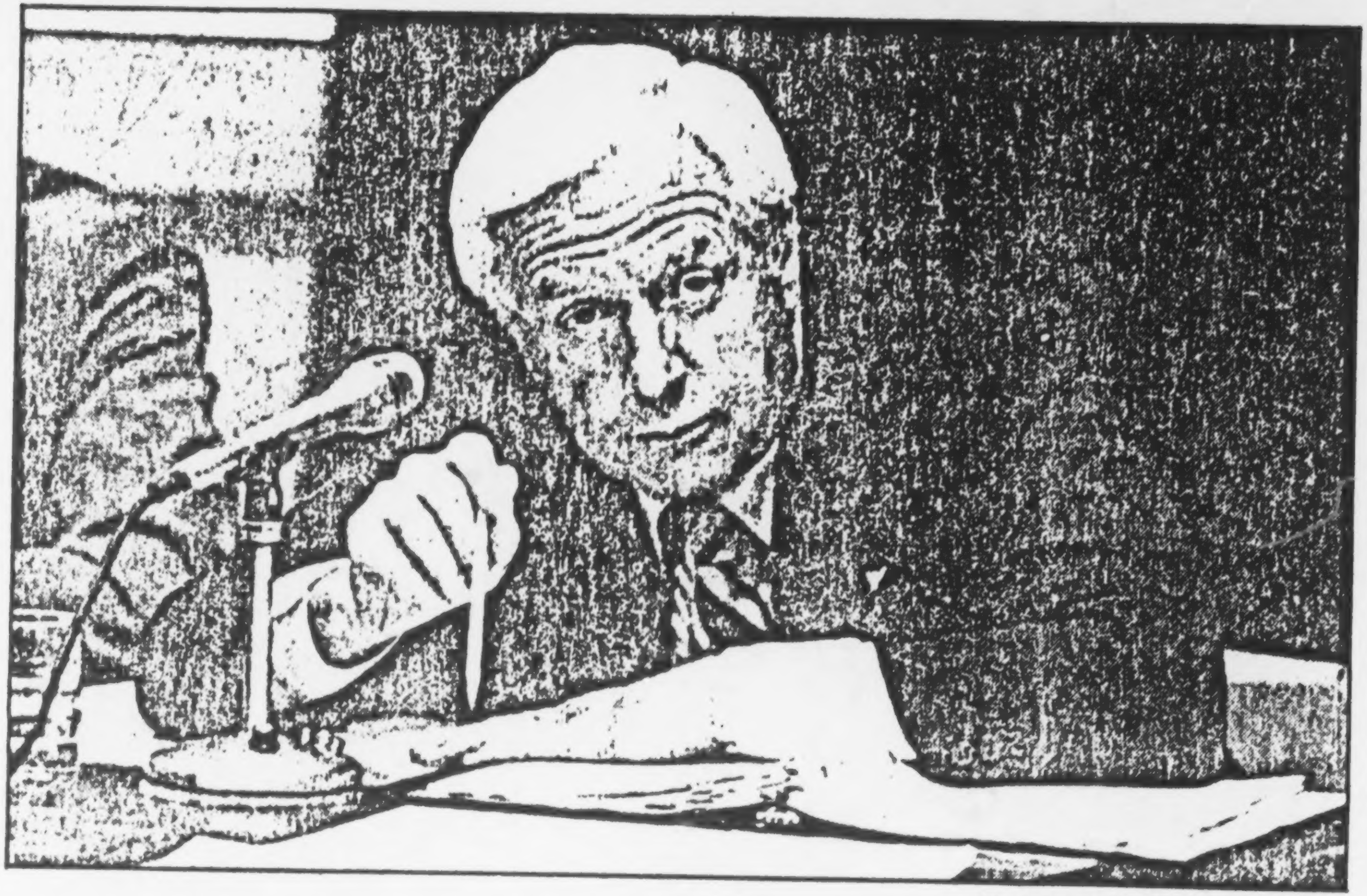
Spiraling costs are making health care unaffordable, according to testimony Wednesday during a congressional forum on health care issues in Cedar Rapids.

Parents faced with obtaining proper medical care for their children, hospital administrators strapped with budgetary restrictions, and industrial representatives who've struggled with providing medical insurance to employees were among those making presentations at the U.S. Congress Joint Economic Committee hearing.

About 100 people attended the four-hour hearing in the nursing auditorium of St. Luke's Hospital. It was conducted by Sen. Roger Jepsen, R-Iowa, who chairs the committee.

According to a Jepsen aide, the information submitted Wednesday will be included in a report to members of Congress and congressional committees addressing health-related issues.

Opening the hearing, Jepsen said the health care dilemma "is much like the weather. It gets talked about but nothing is done." Over $1 billion a day is spent on health care in the U.S., he said.



Gazette photo by John McIvor

Sen. Roger Jepsen makes a point at a health care hearing Wednesday In Cedar Rapids

Jepsen told the audience that Congress and the president "now seem ready" to establish a national policy on health care.

Testimony from members of four panels making presentations during the meeting here, the second of two forums held in the country, can play an important role in developing the policy, he said. The first forum was held earlier this year in Washington, D.C.

Discussions by the 23 panelists included the following:

- Economic conditions of hospitals are having "a profound impact on patients," pointed out Mercy Hospital Administrator Jim Tinker. As hospitals reluctantly cut staff to reduce operational expenses due to revenue losses, Tinker has detected "mounting resentment among patients."

This resentment has surfaced with a new method of paying hospitals for care of federal Medicare patients. The method, using Diagnostic Related Groups, or DRGs, establishes set amounts to be paid the hospitals for each type of medical care.

Consequently, elderly people and others have been released within a day of having cataracts removed from their eyes with no regard given for the assistance they'll have available at home, Tinker complained.

- Julie Beckett, whose young daughter Katie made headlines in 1981 in an example of federal red tape thwarting financially efficient alternatives to hospital care (in Beckett's case, care at home instead of in the hospital), told of her daughter's case and those of other families with similar circumstances. She urged cooperation between government agencies and health care officials to get proper assistance to families.

- Jodi Miller of 126 Harbet Ave. NW quit her job after almost a year of employment because her $573 monthly wages weren't enough to pay health insurance premiums, medical bills, babysitting costs for her young child and other living expenses amounting to about $599 a month.

After quitting her job, Miller and her child became eligible for Aid to Families with Dependent Children, food stamps and Medicaid medical care paid by the state and federal governments. With fewer expenses (a babysitter is no longer needed), Miller said she now has about $80 left after paying her bills.

- Representatives of urban and rural hospitals complained about the difficulty of providing quality care with revenue limitations imposed with the Medicare DRGs.

Hospital officials are looking to partnerships between hospitals and with government and industry as possible cost-cutting measures, according to the president of St. Luke's Hospital, Sam Wallace. However, federal antitrust laws loom as possible barriers to networks between hospitals and in-home nursing agencies, he added.

- Defending medical malpractice lawsuits is an added expense for hospitals and physicians today, the costs of which are passed on to consumers, according to Cedar Rapids attorney James Snyder.

More malpractice claims could arise with the DRG method, he said, because errors in diagnosis could become more frequent with restrictions on keeping patients in hospitals for examinations.

- Industry is taking steps to reduce the need for medical care in an effort to curtail the cost of providing employee health insurance coverage.

Six years after offering a preventative program that includes medical screenings and incentives to employees to be health conscious, Russell Knuth of Pioneer Hy-Bred International Inc. told the committee his company is saving about $1,370 a year on each employee's insurance coverage.

IT'S A GREAT BIG WONDERFUL WORLD

August 26, 84

Honorable Sen Roger Jepsen
Marion, Ia

Dear Senator Jepsen,

I am not able to be at your meeting - in addition to my letter - I would like to comment on the high cost of drugs - several people have told me that .50 is nothing to pay for a few pills. As for myself I am taking Keflex 500 mg - I was told by the druggist each capsule was 1^{00} apiece. I take 4 a day - have been taking them since July 31 - & until approx. Aug 30 I am lucky that I pay only 3^{00} of the cost of each time

(over)

my pill bottle is filled due to my school insurance.

Our son, who is epileptic need to have medication daily and for the rest of his life. The cost of his drug has greatly increased. The people who out of extreme necessity need medicine to live a normal life - the high cost of drugs, is a hardship for them. No doubt, drug companies need to be investigated and was once in a drugstore when a new price list came in - The druggist appeared disgusted.

Aug 16, 1984
358 Garden Dr S E

Honorable Charles Grassley,
Washington, D.C.

Dear Senator Grassley,

I am writing to you in behalf of the Medicare patient or any patient who has had hospital stay cut short. Myself was one such Medicare patient with Blue Cross, Blue Shield & Major medical coverage. July 31, I had 4 toes operated on again. I was given a general and sent home the same day. I felt I was too ill to go home besides we had neither the facilities or the "know how" to cope with my situation. In my case, had I gone back to the hospital, transportation would have been no problem and since I was an outpatient before the operation I was told it would 500 out of my purse to stay for the night.

many persons may [illegible] not have
the ways or means to return in a real desperate need.

The nurse from Surgical did call the next day about 3 P.M. and talked to my husband who really didn't know how I felt or my condition. I have gone to the hospital and discussed with the "Patient Complaint" department many things concerning my experience as an "out patient".

Articles have been appearing in "Letters to the Editor", the C.R. Gazette, concerning recent treatment of Medicare & paying patients. I am enclosing one of them.

I feel the other extreme has now been taken, due to the abuse of the Medicare program by doctors and hospitals. However, those who are being punished, are the patients, and denied the proper care they need, when they need it most. When one is ill, love and caring & security are all so important. As it appears now it seems legal to kill off old people by denying them the care they need when needed most. They Golden years, dying and death due to disease becomes a horror and a fear, to our older citizens with the present plan of Medicare enforcement.

I know you are concerned about Iowa and its people. This is one time when Medicare people need understanding and help.

Sincerely,

Doris E. Larson
358 Garden Drive SE.
Cedar Rapids Iowa
52403

Copies to
Sen. Jepsen
Rep Tauke